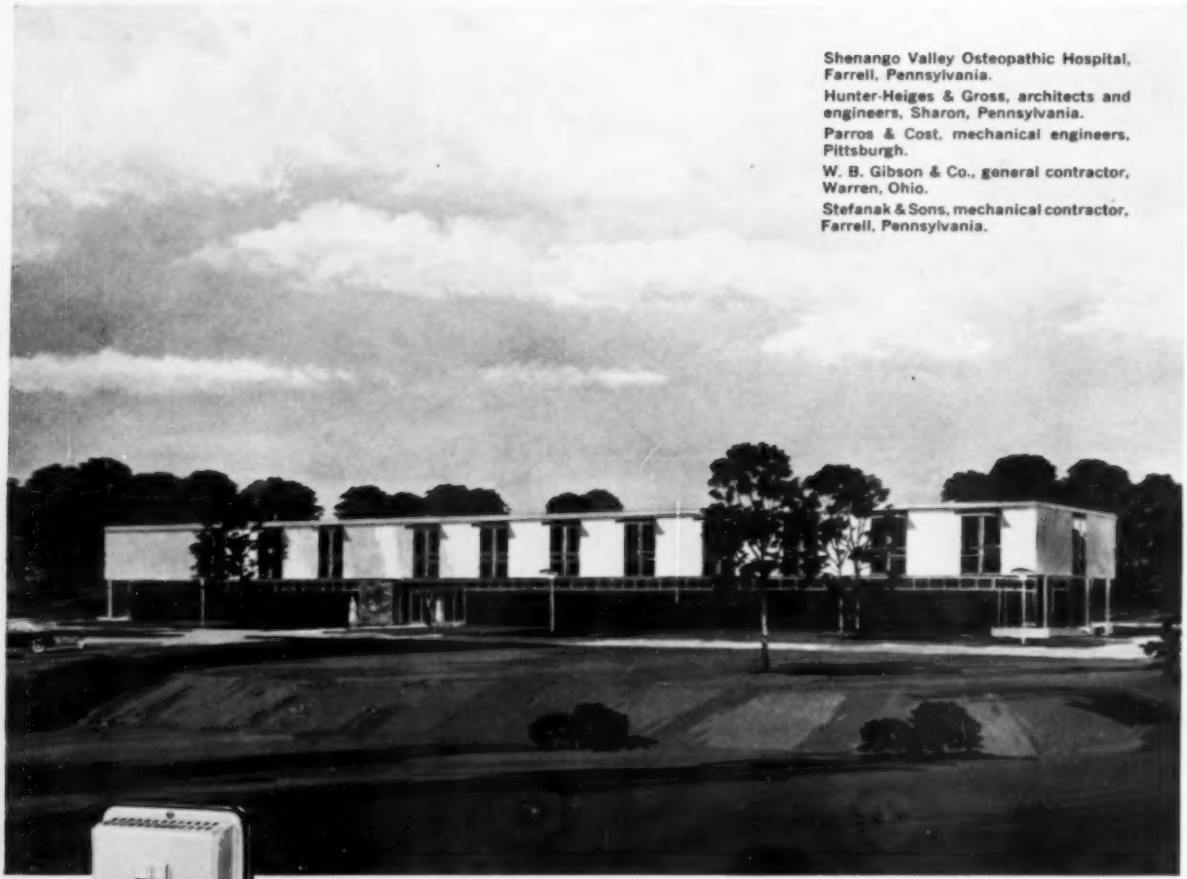
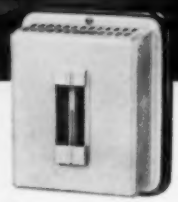
The Modern Hospital

DECEMBER 1961

Meditation room at West Allis Memorial Hospital, West Allis, Wis. (P. 93)



Shenango Valley Osteopathic Hospital, Farrell, Pennsylvania.
Hunter-Heiges & Gross, architects and engineers, Sharon, Pennsylvania.
Parros & Cost, mechanical engineers, Pittsburgh.
W. B. Gibson & Co., general contractor, Warren, Ohio.
Stefanak & Sons, mechanical contractor, Farrell, Pennsylvania.



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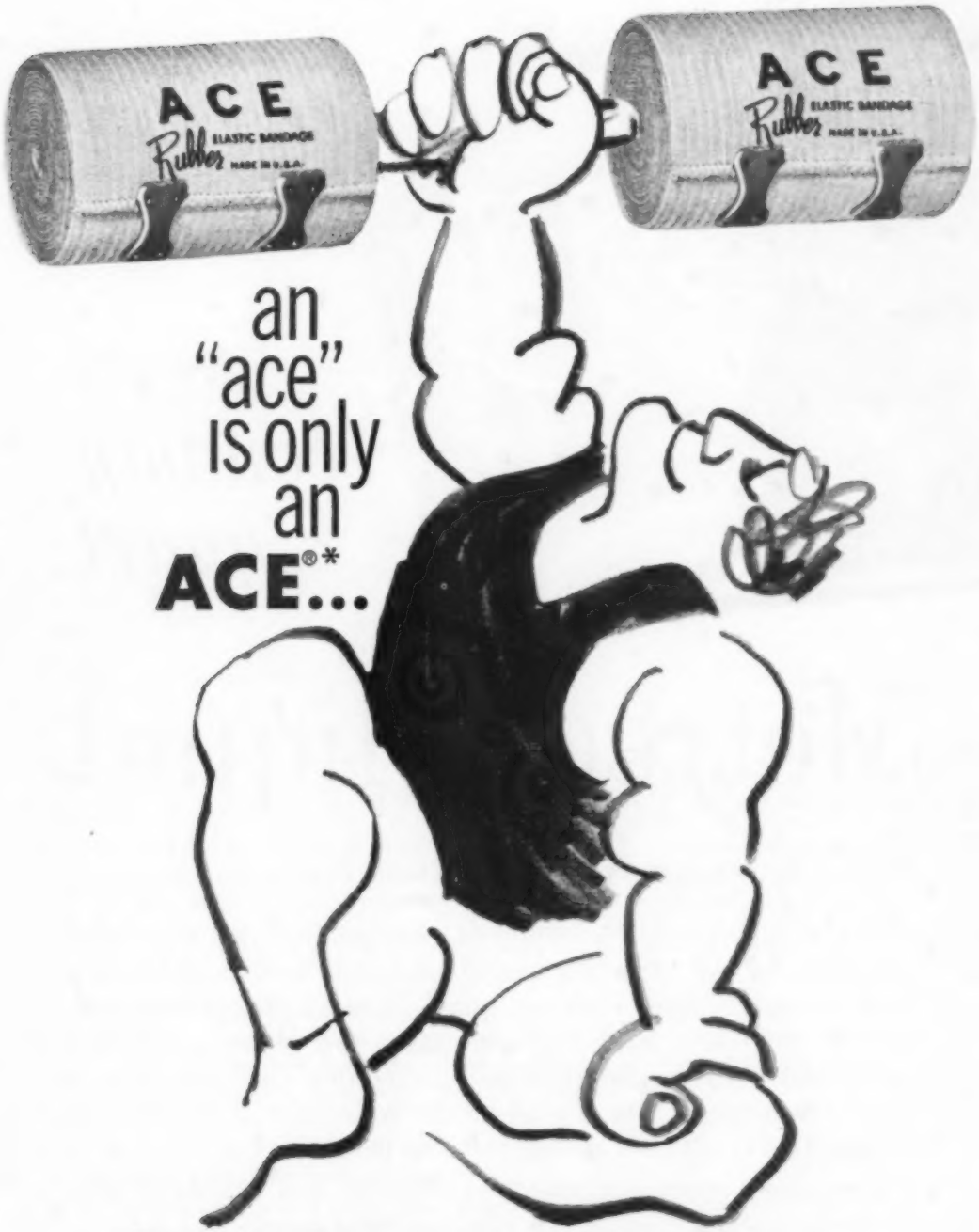

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The Modern Hospital

DECEMBER 1961 VOLUME 97, NO. 6

Continued on next page ▶

The Modern Hospital

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Hospital Lets Father Stay in Delivery Room

Instead of pacing the floor in a waiting room, expectant fathers at St. Mary's Hospital, Evansville, Ind., can be right on hand in the delivery room. Moreover, they can visit their wives and babies any time they choose, stay as long as they like, and go when they please.

These innovations are part of a five-year pilot study on family-centered maternity care conducted by the hospital. "Since we started this program, reports Sister Mary Stella, supervisor of obstetrical nursing at St. Mary's, "no father has ever been in the way, fainted, or otherwise made a nuisance of himself."

Wives want their husbands with them for comfort and support during the ordeal of labor, and husbands want to be there because they feel they are helping, she emphasized. "If the wife is awake during delivery and both of them want it, the husband goes with her to the delivery room," she said. "The doctor, of course, must give permission, and more and more of them are doing so," she added.

Under the St. Mary's plan, the mother returns to her room with her baby in her arms and keeps it with her throughout her hospital stay. The father can come and go as he pleases, and is free to play with the baby, rock it, and feed it.

Since news about the plan began to circulate, couples have begun to come to St. Mary's from other states for the birth of their babies, Sister Mary Stella reports.

"We hear many complaints these days that parents expect the schools to take over the job of rearing their children," she said. "Maybe we hospital people are partly to blame for that by implanting the notion right from the start that care of the baby should be taken over by someone else; that it really isn't the parents' job."

An added advantage of the St. Mary's plan, Sister Mary Stella pointed out, is that the father, too, is made to feel important — "All he's ever done before is pay the bills," she said.

What Nursing Is Like

Nursing as a student experiences it is described in photographs and text in a new book titled "Life of a Student Nurse."

Written by Sister Mary Bernadette, R.N., director of St. Francis Hospital School of Nursing, Wichita, Kan., the book is designed to explain what nursing is and, through the pictures, to provide criteria to help the student decide whether or not she belongs in the profession.

Teletype Speeds Benefits

Teletype service helps Western Pennsylvania Hospital, Pittsburgh, verify Blue Cross benefits for patients in minutes.

The teletype machine, which is connected with the downtown office of the local Blue Cross, saves several days' mailing time in expediting a patient's account.

As the patient leaves the hospital, the cashier's office also uses a teleautograph machine to inform the admitting office and the housekeeping department that a room is vacant.

Hospital Adopts Time-Payment Plan

Time payments help to make large hospital bills seem smaller to patients at Norwalk Hospital, Norwalk, Conn.

The Budget Loan Plan has been inaugurated to give patients time to pay their accounts, and to provide the hospital with a sufficient flow of incoming capital to meet its obligations, according to Richard O. West, administrator.

Under the plan, a patient may be allowed up to 24 months in which to pay his bill. If he holds a charge account with the Connecticut National Bank or any of its four branch banks, he may pay his bill through that account.

To explain the new program to the community, hospital and bank officials prepared a statement of policy change and an information leaflet for patients admitted to the hospital, as well as a descriptive application folder with a visitor's leaflet included.

The bank advertised the plan in all local and service area newspapers; the hospital followed with an explanation to the press which pointed out the necessity of a nonprofit hospital to obtain funds for the bulk of its expenses for wages, supplies and patient care services from payments made by patients or their agents.

During the first month the Budget Loan Plan was put into effect, more than $15,000 worth of business was transacted. "Our experience to date indicates that patients welcome this extension of payment methods, and we feel confident that it will continue to grow," Mr. West said.

Booklet Does Two Jobs

Acquainting new patients with the facilities of the hospital and, in the process, explaining the cost of care, are the purposes of a compact booklet called "Hospitality," published by Glockner-Penrose Hospital, Colorado Springs, Colo.

The first page of the 10 page booklet asks the question, "Hotel or Hospital?" and answers with "Do You Know a Hotel That . . . ?" Each following page contains an example of a modern hospital service, accompanied by a photograph, to point out that a hospital combines the comforts of a hotel with the benefits of medical facilities.

The text explains that the hospital "serves you breakfast in bed (lunch and dinner, too!) with no extra charge," illustrated with a photograph of a patient being served from a bed tray. Next is a picture of a patient being massaged, with the caption, "Lulls you to sleep at night with a professional back rub."

Following pages show services offered to a patient, including a refreshing bath, a wheel chair for indoor transportation, a staff of doctors and nurses to provide care, and professional help available at any hour of the day or night at the touch of a button. More photographs and captions point out that nurses keep an around-the-clock vigil as the patient slumbers.

The "Hospitality" booklet has been invaluable in doing away with misunderstandings, maintaining good will, and obtaining patient cooperation, Glockner-Penrose staff members report.

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They Tip Their Caps to Christmas

Holiday and hospital spirit are joined at Sharon General Hospital, Sharon, Pa., where a special Christmas tree is shaping a new tradition.

Last year, the nursing personnel literally "tipped their caps" to Christmas, with a tree trimmed with caps from each of the nursing schools represented on the staff. A "key to the caps" poster identified the caps on the tree, and elicited a great deal of comment from visitors, ambulatory patients, and the hospital's own employes and students.

To point up the tremendous amount of formal education required by a hospital staff, each school of nursing or technical training and each college or university attended by members of the staff and employes was represented by a tree ornament. A poster located near the tree in the hospital lobby listed these 90 different institutions under the title "It Takes a Heap of Learning."

The cap theme has been carried through to the 1961 Christmas tree, with some creative embellishments that have drawn enthusiastic cooperation from the hospital personnel. This year, the caps are made of paper, and grace the heads of whimsical little plastic foam "characters." The doll faces are simply made of plain plastic foam balls. The "hair" is yarn, glued and pinned in various styles.

Through trial and error, the creators discovered that pancake makeup produces a lifelike "complexion," and bits of pipe cleaners and yarn will fashion easily into expressive eyes and mouths. When finished off with crisp paper collars, the dolls take on real personality.

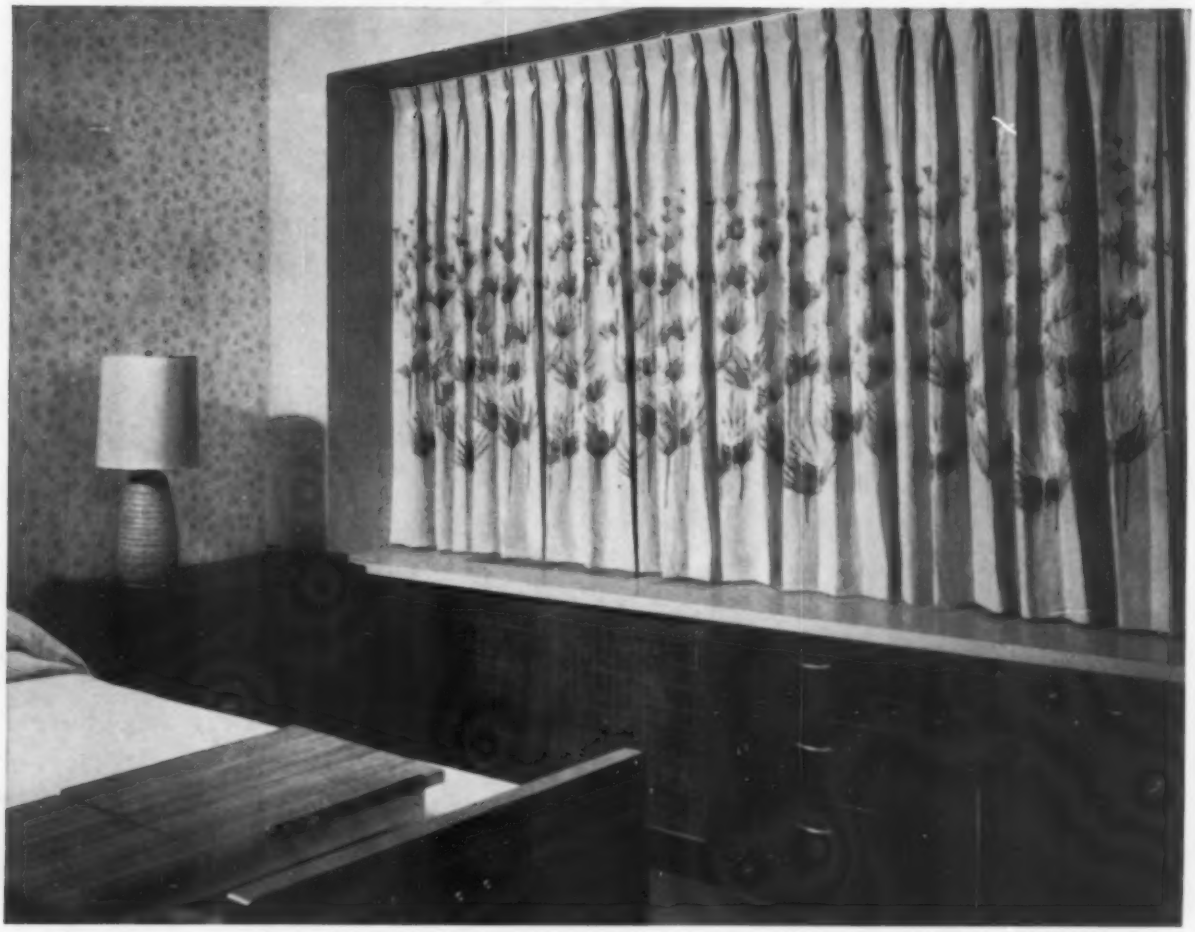
Dozens of these dolls have been made by willing students and employes, who vied with one another to produce the cutest "characters."

The most important by-product of the tree is the attention focused on the largest portion of any hospital budget — maintaining a staff of expensively trained people. The fringe benefit, of course, is the fun and warmth of cooperating on a project that says "Merry Christmas" to the community in a very special way. — V. Terry Klingensmith, *director of personnel, Sharon General Hospital, Sharon, Pa.*

Above: New version of staff Christmas tree. Below: First tree, 1960.

Grant Hospital, Columbus, Ohio

Ben Rose's A.I.D. award-winning "Key" fabrics...woven with ROVANA®



Joseph H. Blake A.I.D., Director of Furnishings and Decorating for the American Hospital Supply Corporation, selected Ben Rose's "Key" Guana fabrics for the Grant Hospital. These champagne draperies made of Rovana*, rayon and Verel† are care-free, safe and *beautiful*. "Key" fabrics are flame- and abrasion-resistant; dissipate static charges readily; are not affected by mildew or fungus. They wash easily, drip dry and require little or no ironing.

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Public Relations

Too Much Explanation Is Better Than Risking Misunderstanding

By Gordon Davis

MR. ERSTWHILE BENEVOLENT, the employer of some 220 men and women, was a good-natured and conscientious boss, sincerely interested in the welfare of his employes. He demonstrated his interest tangibly with the most liberal of employment policies, including Christmas bonuses, birthdays off, loans to meet family crises, free refreshments at coffee hour, and virtually every fringe benefit yet invented.

Consequently, he was more than a little chagrined when he came to work one morning and found the whole force out on strike over a minor grievance.

"I've done everything for these people," he said bitterly. "This is the thanks I get."

What had happened?

You'll find many cases like this in the textbooks of labor relations counselors, all based on the boss who thinks everybody sees the halo over his head just because he does good deeds.

Far from it. Mr. Benevolent's fault was essentially his own. He ignored one of the most godly of human assets, which is the gift of specific communication. In that, Mr. B. had plenty of company. At times, don't we all ignore such communication?

Suppose, for instance, that you were head of a commercial enterprise in a position to give fat Christmas bonuses to all employes this year. Would you consider that merely announcing the bonus was self-explanatory, or should the announcement be accompanied by an explanation of the reasons you were able to share company benefits?

Should you pass out the checks and listen to the cheers, or should you accompany the distribution with a lecture on company progress and the role of each employe in making possible such dividends?

The second alternative sounds crude. On the other hand, it has been demonstrated repeatedly that people – all of us – tend to ignore the relationships between cause and effect in fields with which they are not familiar.

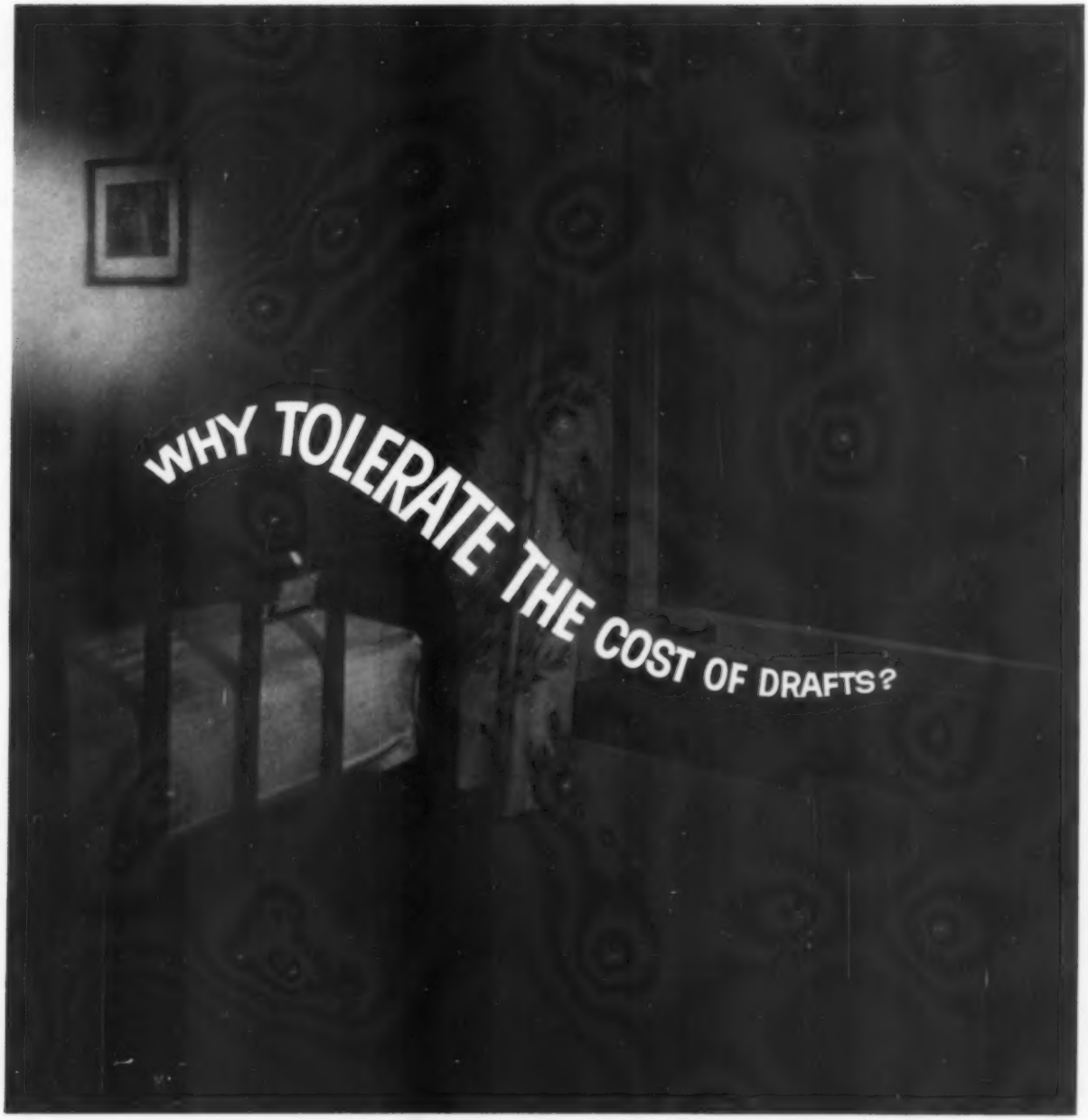
We can see that employes are rendering personal service everywhere in our hospitals, but we fail to relate the pay of these employes to rising hospital costs.

Communication means more than just announcing. It means interpreting. It means giving the reasons why. It means belaboring a point until there is no possibility of misunderstanding. It means reciting the ABC's again and again.

Obvious, isn't it? So obvious that it's just barely possible it is overlooked, on occasion.

Every time you plan a report or an announcement, go back over your plans. Are you just reporting, or are you also interpreting what you have to report? Are you discussing the "why" as well as the "what"? Are you announcing, or are you communicating intelligent awareness? Are you conveying facts or building human understanding?

Good public relations requires that you lean over backward in interpretation, even to the point of seeming tedious. This applies regardless of the nature of your audience; whether it involves the governing board or employes, the medical staff or the public. ■



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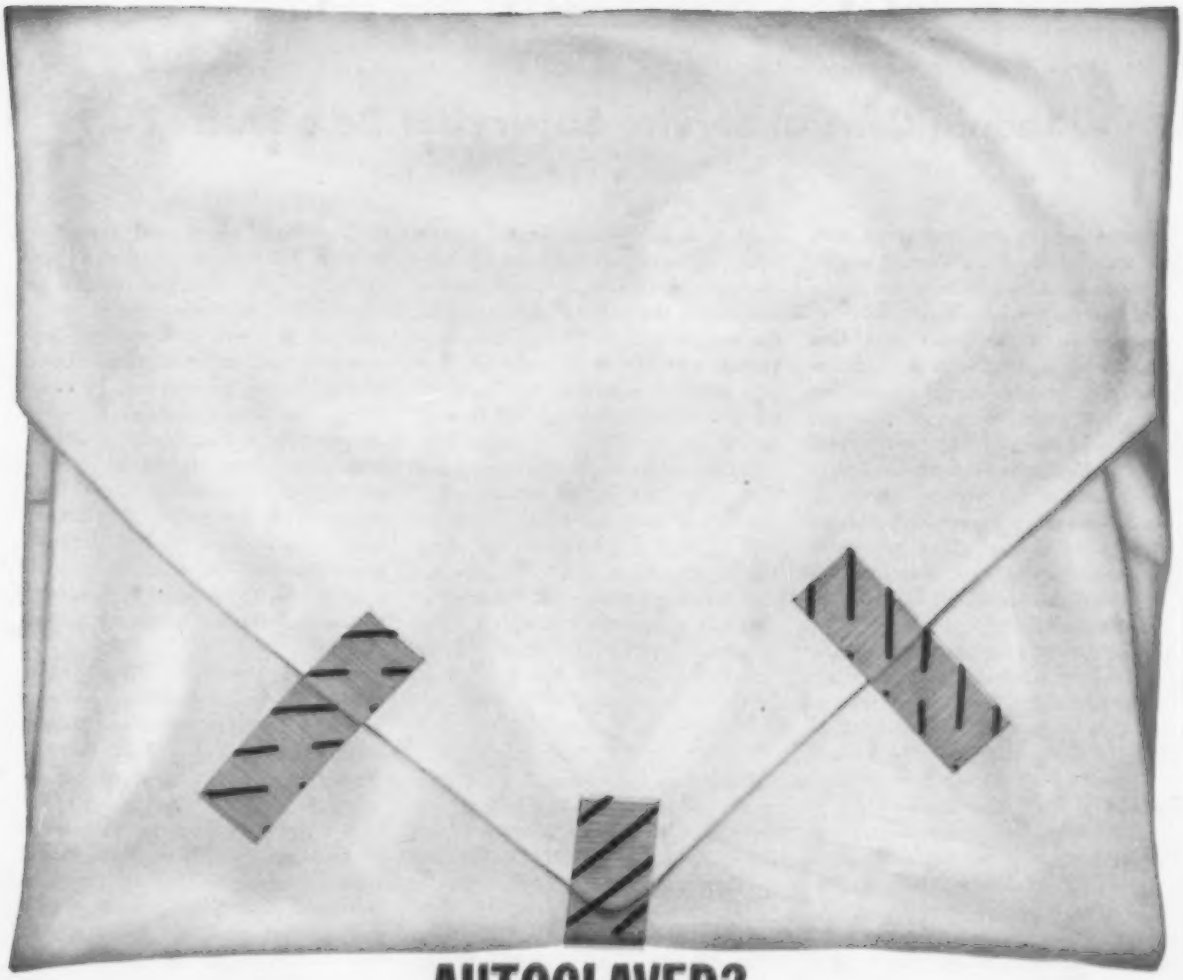

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SMALL HOSPITAL QUESTIONS

Should Central Service Supervisor Be a Nurse?

Question: We are confronted with the resignation of our central supply supervisor, and we believe this is the time to undertake considerable reorganization of the department. Our director of nursing is of the opinion that the central supply supervisor does not need to be a registered nurse, and that the department itself need not be under the administrative supervision of the director of nursing.

Like hospitals everywhere, we are anxious to conserve our supply of registered nurses and, therefore, we feel that this possibility should be explored.

The other evening I raised this question at a meeting of hospital administrators. In general, those present felt that while there was no need for the C.S.S. department to be directly responsible to nursing service, they would be very apprehensive about its being headed by a nonnurse, no matter how thoroughly this person was trained in sterilization technics and the other work of the department. Some administrators felt that only among members of the nursing profession is a hospital likely to find a person who is qualified to handle the position and, at the same time, willing to work for the average salary offered for the job.

One administrator stated that the practice of employing nonnurses in this capacity was growing quite rapidly, particularly in the Midwest.

What are your views on this? — H.M., Pa.

ANSWER: Who should supervise central service and where it should be placed in a hospital's organizational structure is highly controversial. Although I am inclined to agree with your director of nursing, who states that a C.S.S. department need not be supervised by a registered nurse and that the department need not be under the administrative supervision of the director of nursing, there are many qualifications to be considered.

To me, a central service department is an industrial section of a hospital, a processing plant, and a factory. Its operation is an administrative function of the hospital and should be the responsibility of those rare individuals who have knowledge of business methods as well as nursing technics. These individuals should be well versed in administrative procedures, patient problems and technics, and nursing and medical problems.

With a knowledge of people as well as "things," the supervisor needs the personality to provide the leadership necessary to organize a team that will work effectively with all other groups and, at the same time, provide standardized, safe and adequate supplies and equipment for patient care and hospital services.

When properly equipped with autoclaves, labor saving devices, stills and so forth, C.S.S. is a very expensive department that should function as economically as possible. Controls on sterilization of supplies, utilization of supplies, continuous training, and exploitation of labor must be exercised. In the Wesley Memorial Hospital, Chicago, and the Massachusetts General Hospital, Boston, industrial engineers are employed as C.S.S. supervisors. In both of these institutions, the plan seems to be working out well.

The key to effective coordination of a C.S.S. is a technics committee, established by the hospital staff to study clinical needs and formulate recommendations for technics and supplies. This committee should be composed of representatives of medicine, surgery, obstetrics, nursing, laboratories and administration. Once established, technics should be written, published and available to everyone working in the hospital. Purchasing specifications should be written so that the purchasing agent buys exactly what is needed. It is important to emphasize that a technics committee may be impotent unless it is built into the over-all organization of the hospital and given the proper authority.

A good supervisor should know sound work-simplification technics and put them to work. A realistic distribution system should be employed by means of a pickup and delivery truck. This provides for not only the maintenance of stock levels of supplies, but also for management controls to check on lost, stolen or broken equipment and thus to distinguish between responsible and irresponsible wards and services. Appropriate charges must also be carefully controlled.

These are but a few of the responsibilities of a competent C.S.S. supervisor. There are some nurses who are excellent C.S.S. supervisors. The average nurse, however, neither likes the department nor wants to work in it. Many serve in these capacities because there was no one else to assign to the job. I believe that careful selection of an intelligent, mature, nonprofessional person who has business sense and leadership qualities can serve an invaluable function in hospitals, providing:

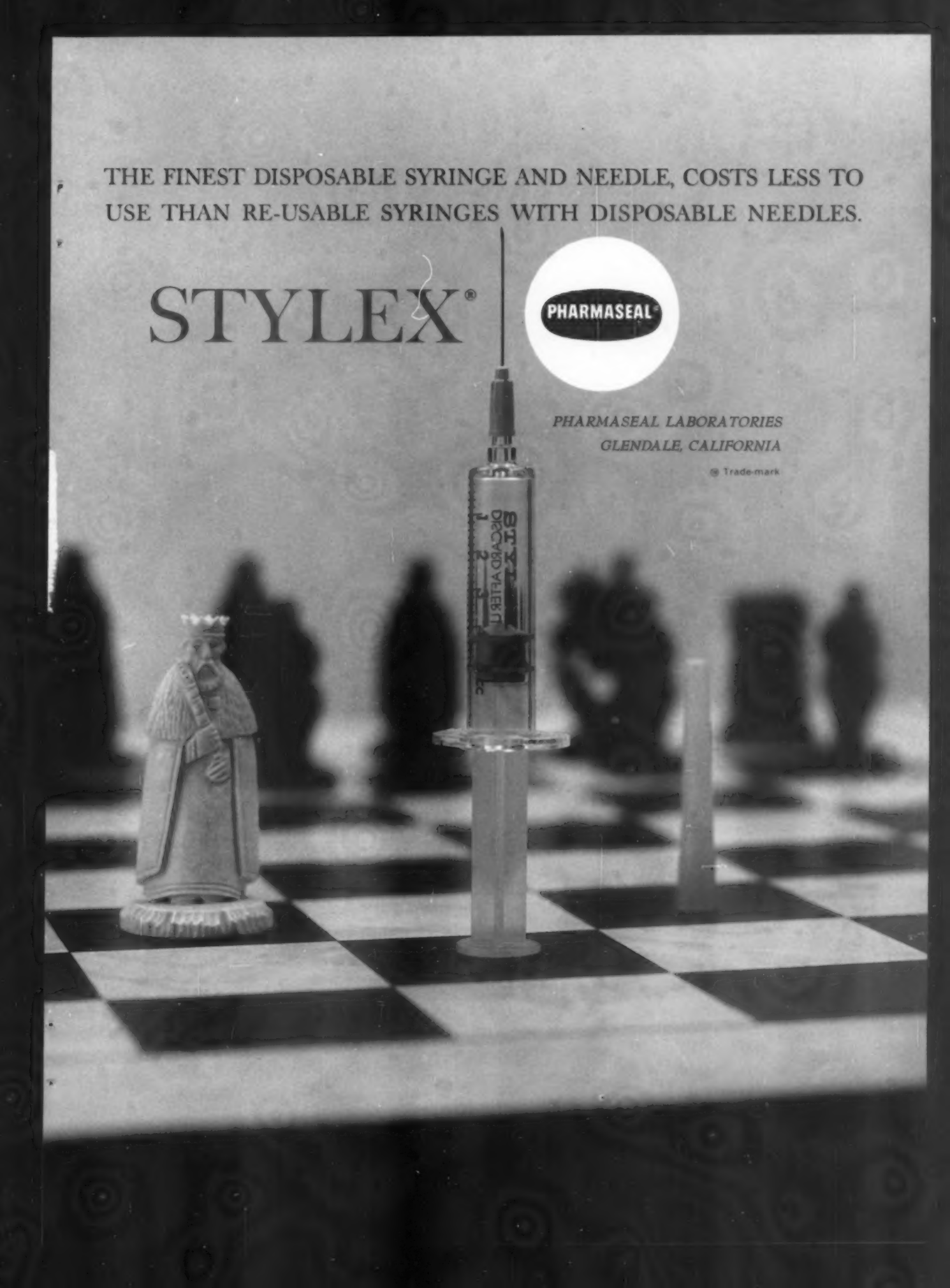
1. He or she is given adequate assistance, training and direction by professional personnel *who want him to learn.*

2. He has an active technics committee to guide him in developing standards and procedures. — FRANCES GINSBERG, R.N.

ANY QUESTIONS?

The Modern Hospital will be glad to try to answer them.

If you have a problem or if you're just curious about a procedure or a statistic, please feel free to write this department, care of The Modern Hospital, 1050 Merchandise Mart, Chicago 54.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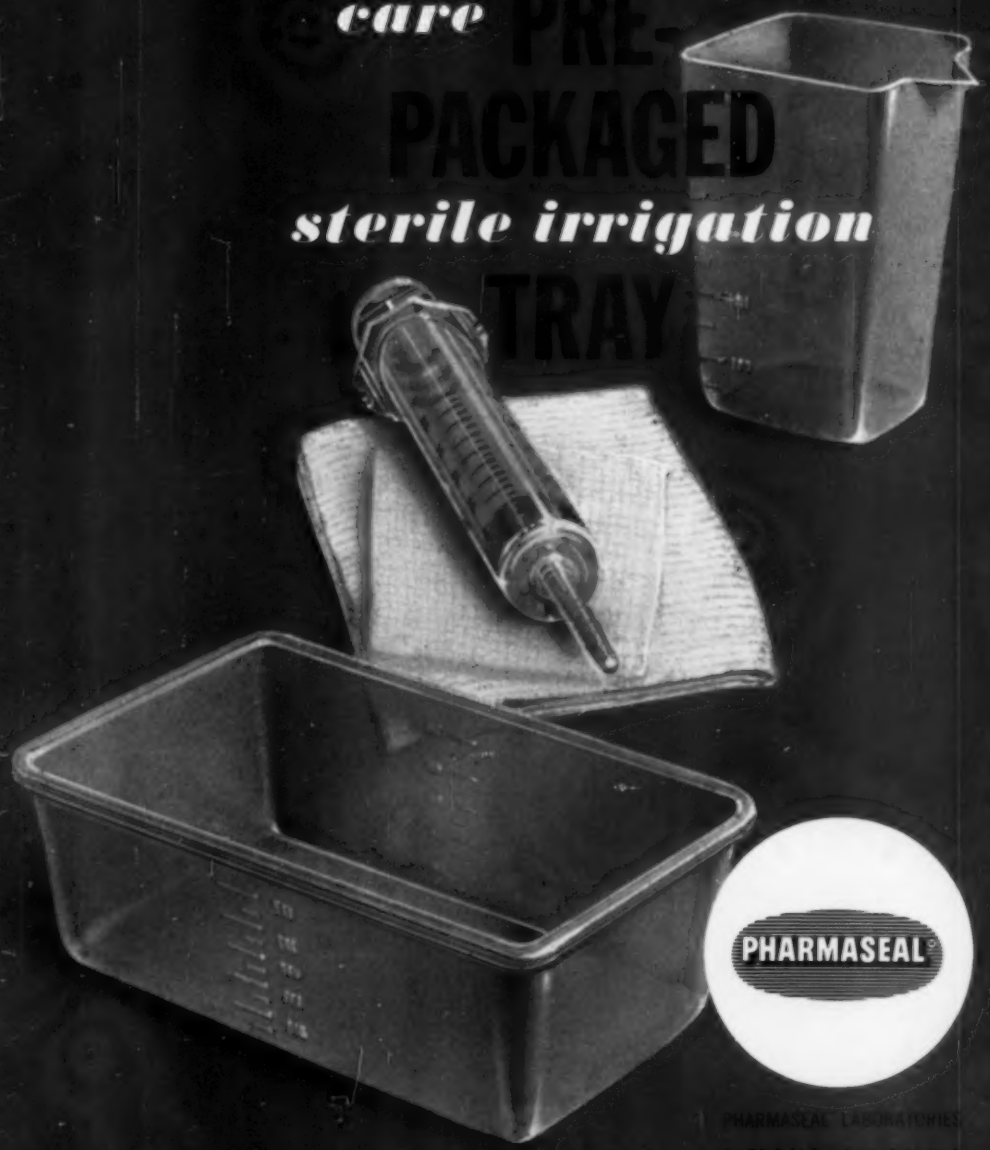

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A.H.A. NEAR DECISION ON AGED

Next January 3 and 4 a special session of the American Hospital Association's House of Delegates will be held in Chicago.

It is convened for one purpose — to decide whether A.H.A. should (1) maintain its position on health care of the aged, (2) give support — probably qualified — to President Kennedy's program for medical care of the aged under social security, or (3) support some other method of providing aid. Because lines are carefully drawn on this issue, the sides are well balanced and a decision is scheduled in Congress next year. What A.H.A. does could well mean the difference between success and failure for the Kennedy plan.

In November an *ad hoc* committee of the A.H.A. board started a study of the whole problem. Formation of the committee was directed by the A.H.A. House of Delegates, which instructed the group to review association policy "with respect to *hospital* needs of the retired aged." Because the study is restricted to "hospital needs," the committee will not look into the problem of payment of "medical" or "physicians" bills. Thus in theory A.H.A. might avoid a direct break with the American Medical Association, leader in the opposition to the Kennedy program.

Proponents of the Kennedy plan within the A.H.A. are arguing that federal financing of *hospital* costs would not mean interference with hospital management or with the practice of medicine. They cite experience under such federal programs as Medicare, federal employes' health benefits, and retired federal employes' health benefits as evidence that the U.S. can pay hospital bills, yet not attempt to interfere with hospital operations.

Members of the A.H.A. committee now preparing its recommendations are Frank S. Groner, administrator of Baptist Memorial Hospital, Memphis, chairman; Alvin J. Binkert, executive vice president, Presbyterian Hospital, New York; Ray E. Brown, vice president, University of Chicago; George E. Cartmill Jr., superintendent, Harper Hospital, Detroit; Donald W. Cordes, administrator, Iowa Methodist Hospital, Des Moines; Dr. Herman E. Hilleboe, commissioner of public health, New York State Bureau of Health and Hospitals; Rt. Rev. Msgr. Donald A. McGowan, director, Bureau of Health and Hospitals, National Catholic Welfare Conference, Washington, D.C.; Boone Powell, administrator, Baylor University Medical Center, Dallas; Lester E. Richwagen, administrator, Mary Fletcher Hospital, Burlington, Vt.; Clyde L. Sibley, administrator, Birmingham Baptist Hospital, Birmingham, Ala., and Samuel J. Tibbitts, administrator, California Hospital, Los Angeles.

Predicting what action the committee will take, and then whether it will be supported by the House of Delegates, would be fruitless. However, it is reasonable to question whether A.H.A. would stage an expensive two-day special session of its House of Delegates merely to reaffirm the association's past policy. Up to now, A.H.A. has stood firm with the A.M.A. in opposition to any specific bills providing medical care under social security, but with the reservation that this solution of the problem may ultimately be found necessary.

The attitude of those within A.H.A. who favor the Kennedy approach was summed up at the convention by Dr. Russell A. Nelson, director of Johns Hopkins Hospital, former association president, who said:

"What about the situation of the retired aged who are above the level of medical indigency? Our association always has considered that federal legislation would be necessary for the care of the aged and it has felt that the social security mechanism might have to be used ultimately. We have federal legislation now in the Kerr-Mills bill. Is it enough? I do not think so.

"Our self-supporting aged still cannot afford adequate coverage from voluntary prepayment agencies. Many, probably a majority, of our Blue Cross leaders feel that Blue Cross cannot do this alone. I believe now the association should work toward a plan to cover the serious needs of the more solvent aged. Whether the money needed for federal subsidy is raised through the social security tax or some other mechanism is a matter about which we in hospital and medical work should not be primarily concerned.

"We can all have our individual feelings about what is the proper way to tax people, but our real concern should be that its benefits are those we know to be valuable in the care of the aged, how they are administered, how payment is made, and what effect a plan will have on hospital care for other people."

The only "compromise" in sight for A.H.A. is one that A.M.A. and other opponents of compulsory health insurance would regard as surrender to big government. It calls for social security coverage for those eligible, but as an alternative, government payment for part of the premiums for voluntary health insurance. Essentially this is the system advocated by Sen. Jacob Javits, New York Republican.

14 Persons Reported Dead in Hospital Fire

HARTFORD, CONN. — Fourteen persons were reported dead in a fire at the 826-bed Hartford Hospital here on December 8. The fire spread through the upper three floors of the institution before it could be controlled.

DRUG HEARINGS START AGAIN

In early December, spokesmen for the pharmaceutical industry have another chance to go before Sen. Estes Kefauver's antitrust and monopoly subcommittee and explain what's good about the drug-makers.

They are prepared with voluminous testimony to show how much the industry invests annually in research and development, the number and variety of Ph.D.'s, M.D.'s and other highly trained personnel at work on new drugs, the amount of money the industry pays in taxes, the num-

ber of valuable new drugs developed each year, the degree of competition that exists in the industry, and other similar favorable points that in the past Chairman Kefauver has not appeared to recognize.

Industry's representatives made their first appearance before the subcommittee in late 1959 and 1960. Then the subcommittee was in its "investigative phase." Now it is conducting "legislative" hearings on a bill introduced earlier this year by Senator Kefauver. In effect, however, there is a great deal of similarity in the hearings; Senator Kefauver still controls them and still repeats his charges that there is too much concentration in the industry and too little competition; that a few large companies dominate production and sales; that profits on new "wonder drugs" are exorbitant by any standards.

Senator Kefauver would correct the situation by moving in two directions. He would make it illegal for drug companies to reach private settlements when involved in arguments over a patent, and he would require drug manufacturers to grant licenses three years after a drug patent issues. Also, he would greatly tighten up machinery used by Food and Drug Administration to check up on the manufacture and processing of drugs.

While Senator Kefauver has called up a parade of witnesses to support his ideas, he has been notably unsuccessful in winning backing from Administration spokesmen.

INFLUENZA THREAT IS WANING

With influenza vaccine supplies low, U.S. Public Health Service—and the public—are waiting on nature for cooperation. If weather continues mild or even normal in most parts of the country to mid-December, no problem is in sight. If extremely cold and rainy weather arrives in many parts of the country before that date, there may be real trouble. This is how P.H.S. summarizes the situation following a nationwide "run" on the vaccine earlier in the fall.

In mid-October P.H.S. put out a routine announcement. It mentioned that up to that time little influenza had been reported, but following its policy the agency urged that the "susceptible groups" be given preference. These are victims of chronic diseases of heart, lung and circulatory systems; pregnant women, and those over 65 years of age. Generally these groups account for most influenza-related deaths.

At that time P.H.S. admitted that the vaccine was in short supply, but anticipated that stocks would be ample to immunize the high risk groups by January 1. It suggested that protection might be limited to one injection until the vaccine supply had increased. Also, it was pointed out that manufacturers were stepping up their production.

A few days after the P.H.S. announcement, a national wire service story sounded a new and sharper warning. This apparently stimulated demand for vaccine, particularly from employers who resorted to mass vaccinations to hold down the absentee list during cold weather. The result was a nationwide pattern of shortages, occurring at about the same time.

Now, P.H.S. is convinced the danger point is about passed — provided the weather cooperates. It anticipates there may be a reserve supply of between 2 and 3 million doses by the first of the year.

Position on Fee Splitting Has Been Incorrectly Interpreted by Surgeons' Group, A.M.A. Asserts

DENVER. — The American Medical Association rebuked the American College of Surgeons for incorrectly interpreting the A.M.A. position on fee splitting as a "retreat."

Meeting here in late November, the A.M.A. House of Delegates also:

— Reaffirmed A.M.A. policies stating that (1) physicians should be permitted to prescribe drugs by either generic or brand name and (2) it is not unethical for a doctor to own or operate a pharmacy if patients are not exploited.

— Approved a recommendation appointing a special House committee to investigate all facets of the operation of the Joint Commission on Accreditation of Hospitals.

— Strenuously opposed social security health care programs.

— Postponed action on the A.M.A. medical discipline program.

Final action by the House on A.C.S. statements regarding A.M.A. policy on fee splitting was softened somewhat after a report indicated that the A.M.A. Board of Trustees will meet with the A.C.S. Board of Regents next month to discuss the statements. The House said it agreed with the intent of five resolutions sharply criticizing the A.C.S., but did not approve the resolutions.

Instead, it approved a reference committee report stating that the committee did not "wish to fan the flames of controversy ignited by the statements of the American College of Surgeons. On the other hand, the committee feels the House has an obligation to its membership — which includes physicians in all types of practice — to agree with the indignation manifested by the introduction of these resolutions and in the discussions before the committee.

"This is all the more important because the position of the American College of Surgeons is based on an incorrect interpretation of the action of this House which in no sense is a retreat from its position of firm opposition to fee splitting."

Earlier, the president of the A.M.A., Dr. Leonard W. Larson, called on the medical profession to support its friends in Congress with funds and campaign assistance as well as "a friendly letter."

Proposals to incorporate health care benefits into the social security system, Dr. Larson said, "would certainly represent the first major, irreversible step toward the complete socialization of medical care."

After extended discussion, the House also referred back to the A.M.A. Council on Constitution and Bylaws a proposed bylaw change permitting the A.M.A. to take action against unethical doctors even if no action was taken by local and state medical groups.

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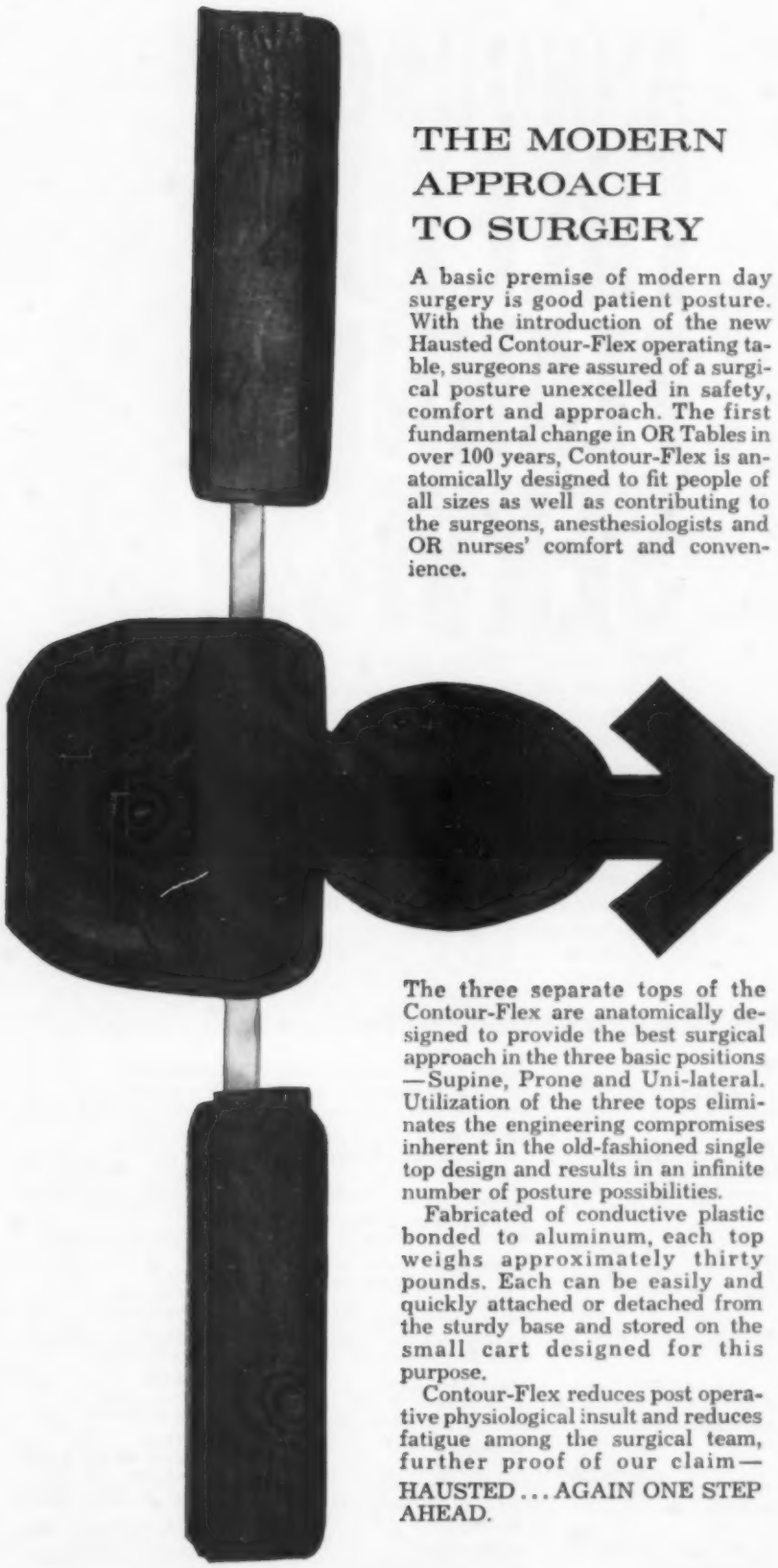

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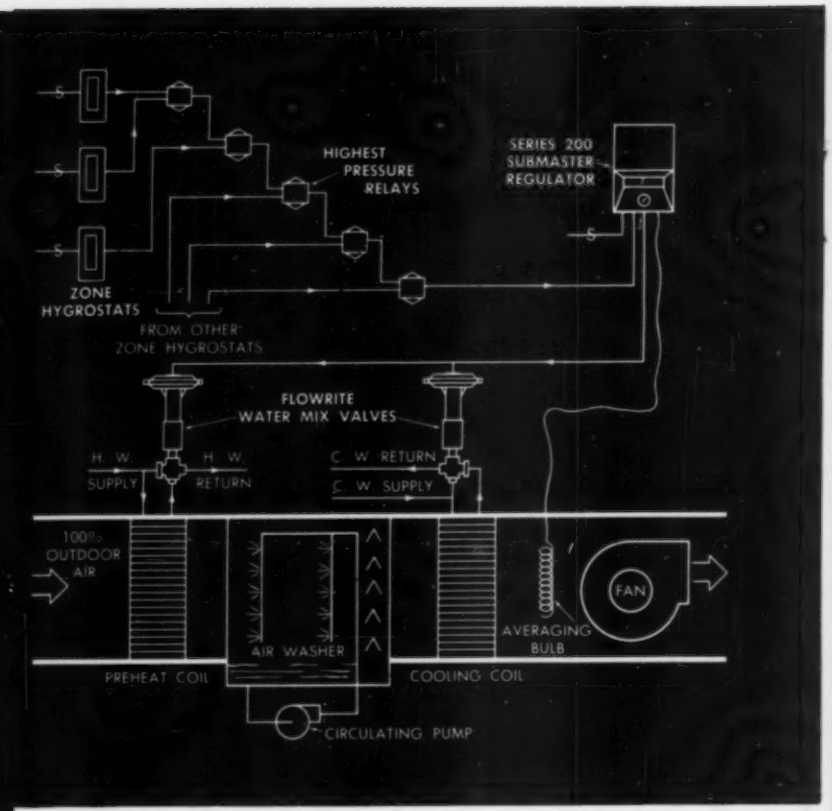

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Heading up the planning staff were (left to right): Consultant, Gordon A. Friesen; Consulting Engineer, John F. Reardon; Architect, Gene Verge; and Administrator For Holy Cross Sisters, Sister Olivia Marie.

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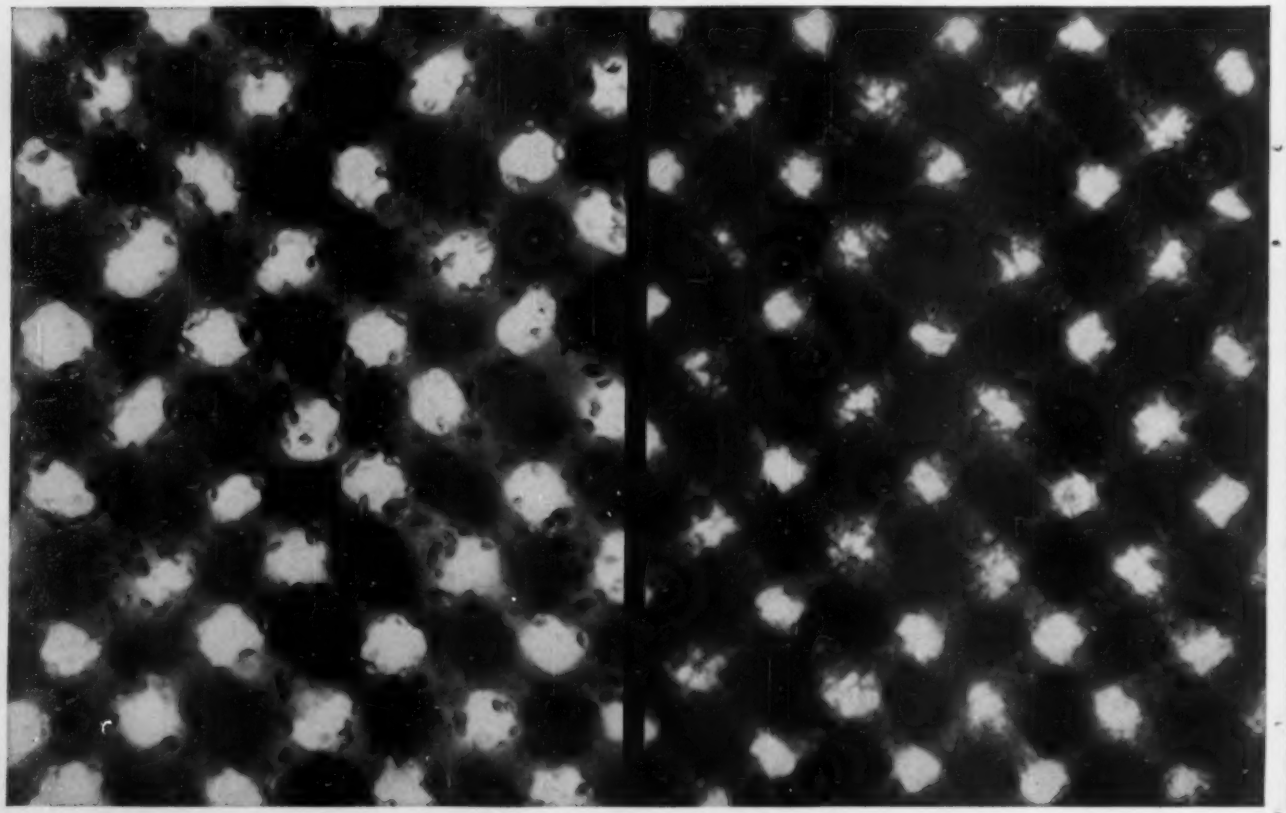

These companion photomicrographs show Velva-Soft-G's effective antibacterial control on a laundered sheet placed in a suitable medium seeded with Staphylococci. At left is the untreated sheet with dark "staph" colonies growing profusely. At right is the sheet treated with Velva-Soft-G. This picture clearly shows that Velva-Soft-G inhibited bacterial growth.

What Velva-Soft-G is:

It is a special cationic fabric softener with specific antibacterial chemicals to control a wide spectrum of germs, including the antibiotic-resistant strains of Staphylococcus aureus. Because of its cationic charge, Velva-Soft-G readily attaches itself to fabric when it's applied in the last cycle of the laundering operation.

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Resistant strains of Staphylococcus aureus are held responsible for patient infection in many hospitals. Velva-Soft-G was developed to help hospitals' over-all environmental sepsis program—by controlling the spread of organisms on lint. The final formula evolved from variations tested on approximately three million pounds of hospital-washed linens.

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Velva-Soft-G does even more:

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*Upper figure represents beginning of operation, lower figure the end.

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Total Organisms per Ml.*								
1. *Water Only* (no load)	1 1	1 1	0 0	1 2	4 4	1 2		1.5
2. *Regular Load* (bed jackets) Never treated with germicide	130 130	20 22	100 170	130 110	225 110	165 290	320 200	155.0
3. *Regular Load* (bed jackets) Treated with Velva-Soft-G before patient use	1 0	0 0	1 1	2 1	3 2	1 0	0 0	0.9

The over-all average indicates that Velva-Soft-G apparently reduced the high growth of organisms to the virtually germ-free level of the tap water.

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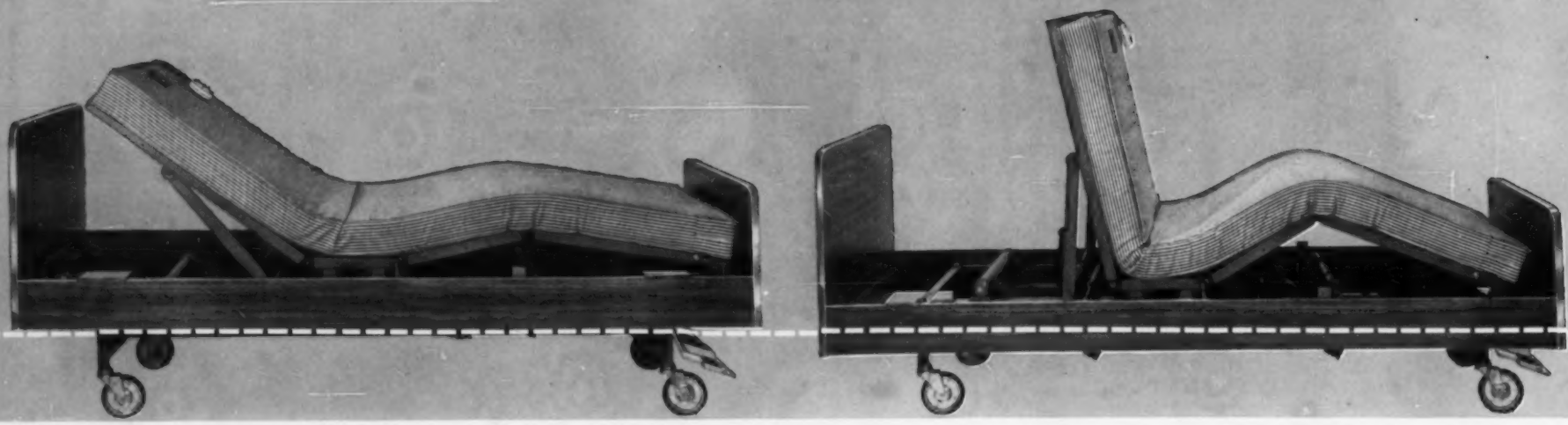

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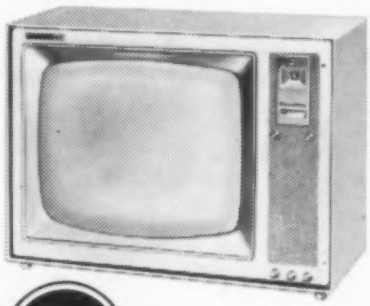

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year-round "preventive medicine" keeps your G-E x-ray equipment in top-shape...

PERIODIC TUNE-UP PREVENTS TROUBLE

. . . With G-E Planned Maintenance Service you are always sure of performance from x-ray equipment. We employ and train our own servicemen who check and adjust electrical parts; replace them if faulty; do all necessary cleaning; adjust and lubricate mechanical parts; adjust and confirm radiographic calibration. All without charge for labor. Your regular, fixed PMS fee fully covers their work.

REGULARLY SCHEDULED SERVICE EXTENDS EQUIPMENT LIFE

. . . How often your own G-E x-ray apparatus receives periodic care is governed by type of unit and your work load. Each PMS visit is carefully planned in keeping with your wishes so as not to disrupt schedules. PMS-protected equipment rarely needs emergency service: You rule-out most unexpected breakdowns by systematic preventive care!

Litho in U.S.A.

Emergency service during office hours provided free of extra cost!

G-E Planned Maintenance Service provides speedy emergency help when the occasion arises. You can forget going through channels—save valuable time—since *no purchase order is necessary.* Emergency service is yours during business hours simply for the phone call to your General Electric x-ray office!

This holds true whatever the cause of difficulty, even when brought about by operator error; you pay only for parts; *not a cent where functional adjustment can restore operation.*

Planned Maintenance Service is a G-E exclusive—*exclusively* for General Electric x-ray equipment! Proven means for minimizing your x-ray maintenance costs. For further information, contact your G-E x-ray representative.

Progress Is Our Most Important Product

GENERAL ELECTRIC

Can you afford to give away medication?

As hospital costs mount, it is becoming increasingly evident that the beneficiaries of hospital services—the patients—must assume their fair share of the costs incurred. For this to occur, the hospitals must be able to account scrupulously, either to the patients or to the various prepaid hospital plans, for all services and medication.

Old-style injections too complicated

Because accounting and billing for medication withdrawn from multidose vials has been so difficult and time consuming, many hospitals have virtually been forced to write off the cost of common injectables or, at best, to estimate them. Yet it is clear that few hospitals can afford to give away medication or to rely on estimates, which are often unacceptable by the prepaid plans.

TUBEX lets you charge fairly

The TUBEX system provides individual, unitized doses of medication in tamper-proof cartridge form. It's an easy matter to keep track of medication dispensed and administered. ***You know just what each patient received, and precisely how much. And you can charge accordingly, with unassailable fairness.***

The need to charge accurately and as completely as possible is being met by the TUBEX system in more and more hospitals across the nation. Typical of the accolades the system has won is the following, excerpted from *The Bulletin of the Parenteral Drug Association:*

The charge made to the patient should include all services rendered. When most of these services are built into the product by the supplier—guaranteed identified contents and dosage, guaranteed sterility, plus simplified record keeping and control—and included in a single purchase price paid to the supplier, there is no problem in justifying the charge to the patient. It is a charge that can easily be backed up by records, and it does not strain the credulity of any investigator.—Crohn, L.B.: The Bulletin of the Parenteral Drug Association, p. 23, March-April, 1960.

If you want to learn more

Your Wyeth Territory Manager will be glad to give you all the details about the TUBEX system. Or, write to Wyeth Laboratories, P.O. Box 8299, Philadelphia 1, Pa.

TUBEX® Closed Injection System, Wyeth
TUBEX®, *Hypodermic Syringe, Wyeth*
TUBEX®, *Sterile Cartridge-Needle Unit, Wyeth*

STERILIZE

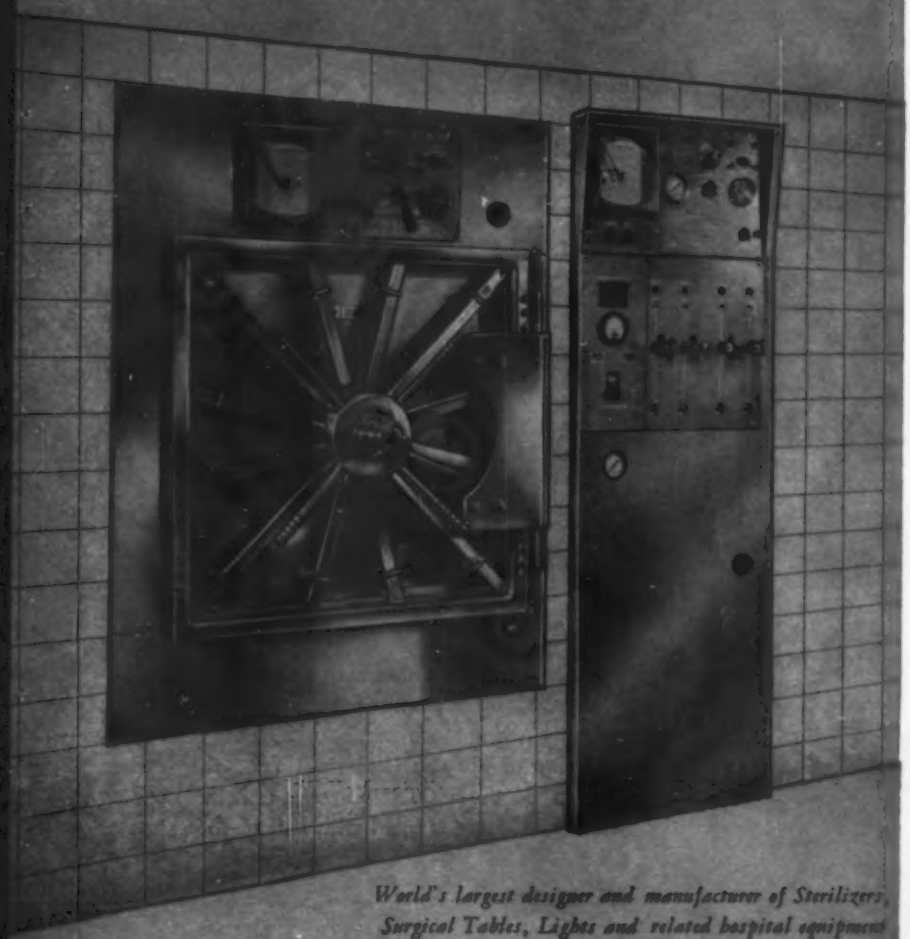
ONE LOAD by PRESSURE STEAM . . . the NEXT by "COLD" Ethylene Oxide Gas

with Amsco's Combination Gas-Steam Sterilizer

Never before has such a versatile, efficient sterilizer been offered to hospitals . . . never before has gas/steam sterilization been made *so safe, so trouble-free*. Simply flick the controls and you're ready for either pressure steam, or "cold" ethylene oxide sterilization. And both cycles are fully automatic.

Today, hospitals using Amsco's Combination Gas-Steam Sterilizers are processing an ever-mounting list of heat-or-moisture sensitive materials . . . Heart-Lung Machines, anesthesia equipment, plastic bassinettes, electrical apparatus for surgery, toys, books, cameras . . . an almost endless list. This is a sterilizer that "asks" to be kept busy twenty-four hours every day.

If you haven't investigated the economies offered by Amsco's Combination Gas-Steam Sterilizer, *please write for literature*. Chamber sizes, mounting styles and ethylene oxide mixtures will meet your particular needs.



This 16" x 16" x 30" "Cryotherm" Cold Sterilizer is ideal for sterilizing instruments and pre-packaged surgical and laboratory supplies. Easy-to-use, disposable aerosol containers of "Cryoxcide" gas make its use efficient and economical. *Write for SC-310.*

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

World's largest designer and manufacturer of Sterilizers, Surgical Tables, Lights and related hospital equipment

1. One Half-Sling is placed in each semi-circular Loading Tub.

2. Loading Tubs containing Slings are placed in front of washer for fast, convenient loading.

3. When loaded, semi-circular Tubs are placed back to back. Loaded Half-Slings are then attached to Lifting Ring for hoisting out of Loading Tubs.

For NOTRUX® Extractor users . . .

The swing is to Slings - Half-Slings that is!

Now, laundries using NOTRUX Extractors can have all the advantages of sling operation plus the unusual convenience and efficiency afforded by American's new Half-Sling Design.

Using two Half-Slings instead of a single full sling simplifies and speeds up dumping of extracted work, increases production by giving more extractor loads per hour!

Half-Slings divide the load right from the washer. Designed to fit the NOTRUX'S semi-circular Loading Tubs, each Half-Sling is filled with half of the extractor

4. Half-Slings, attached to the Sling Lifting Ring, are lowered as a single unit into the NOTRUX Extractor.

5. After Half-Slings are lowered into Extractor basket, the Sling Lifting Ring is detached from the electric hoist and is secured to the locking post on the cone at the center of the Extractor basket. Lifting Ring stays in the Extractor with the Slings during extraction.

6. After extraction, the Lifting Ring, with Slings attached, is hoisted from the Extractor.

7. Lifting Ring in position for dumping each Half-Sling individually. Operator pulls lever which releases bottom tails of one Half-Sling. Weight of work opens bottom of Half-Sling and work falls free without pulling or tugging. Other Half-Sling is dumped in the same manner.

load. The two Half-Slings are hoisted as a single unit into and out of the extractor. Each Half-Sling is dumped independently because one half of the extractor load is the same capacity as most hampers and most drying or conditioning tumblers.

NOTRUX Extractors can be converted to sling operation right in your plant in approximately one hour. There's no need to wait any longer. Call your nearby American representative today, or mail the coupon for complete information.

You get more from **American**

American Laundry Machinery Industries
Cincinnati 12, Ohio

ALM-826

Send complete information on the new Half-Slings for NOTRUX Extractors.

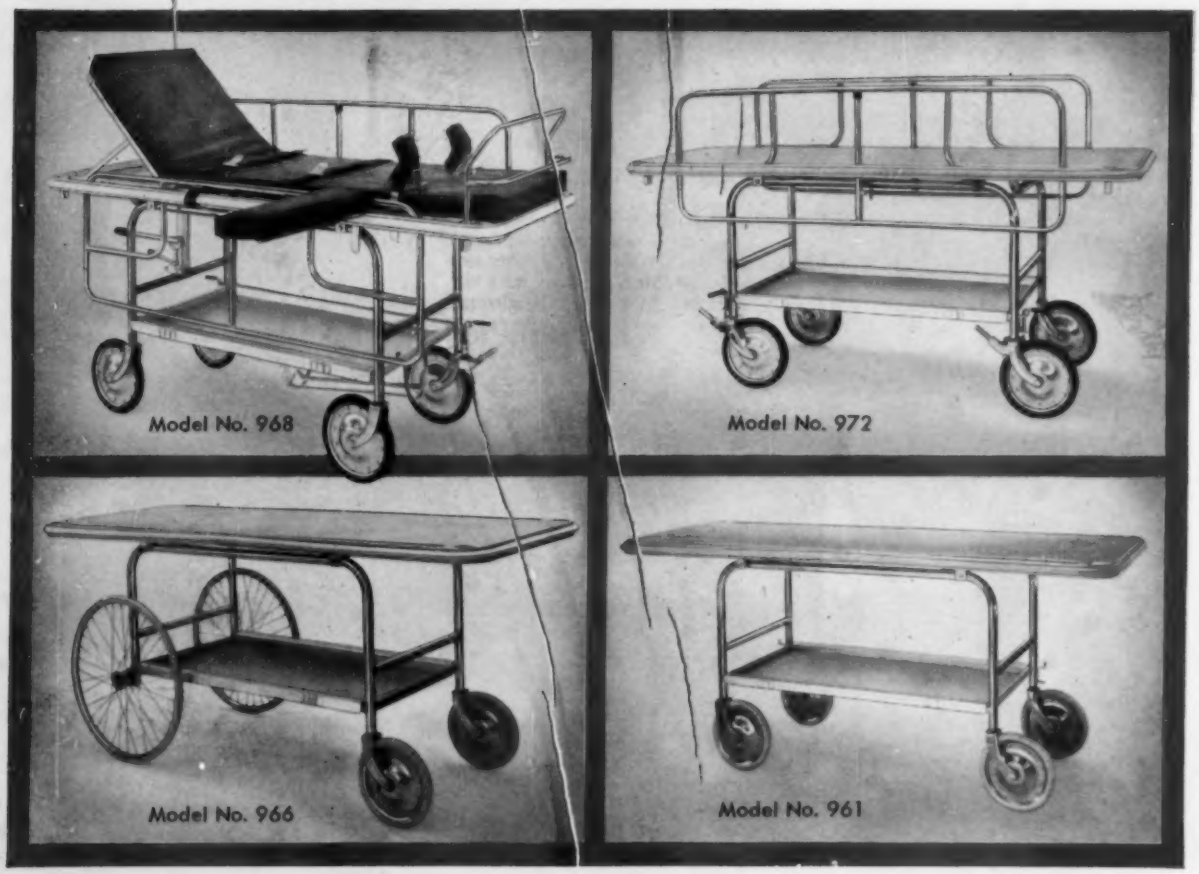
Name_____

Firm Name_____

Address_____

City_____ Zone____ State_____

Finer Equipment at Lower Cost!



Gendron's Complete Wheel Stretcher Line

Yes, if it's a genuine Gendron, it's the finest of its kind, and at a cost to fit any hospital budget. This all-new Gendron wheel stretcher line has been designed and manufactured with the usual Gendron quality features with ruggedness, ease of handling and patient comfort foremost in mind.

Many features, including Gendron exclusives, such as 1¼ in. Steel Tubing throughout, are standard equipment. However, a complete line of accessories to assure proper patient care are available at a minimum additional cost. Write for Catalog #WS-61, or see your nearest Gendron supply dealer.

GENDRON . . . FOR OVER 85 YEARS THE QUALITY MANUFACTURER OF WHEELED EQUIPMENT FOR THE PATIENT OR THE HANDICAPPED

THE GENDRON WHEEL COMPANY
PERRYSBURG, OHIO

NOW SHIP IT FASTER

When hospital supplies are needed, they're usually needed fast. Remember Greyhound Package Express. Even shipments going hundreds of miles can arrive *the same day they're sent!*

Whatever the destination of your shipment, chances are, a Greyhound is going there anyway... *right to the center of town.* Greyhound travels *over a million miles a day!* No other public transportation goes to so many places—so often.

You can ship anytime. Your packages go on regular Greyhound passenger buses. Greyhound Package Express operates twenty-four hours a day... seven days a week... *including weekends and holidays.* What's more, you can send C.O.D., Collect, Prepaid ...or open a charge account.

CALL YOUR LOCAL GREYHOUND BUS TERMINAL TODAY...OR MAIL THIS CONVENIENT COUPON TO:

GREYHOUND PACKAGE EXPRESS
Dept. M18, 140 S. Dearborn St., Chicago 3, Illinois

Gentlemen: Please send us complete information on Greyhound Package Express service... including rates and routes. We understand that our company assumes no cost or obligation.

NAME_____ TITLE_____

COMPANY_____

ADDRESS_____ PHONE_____

CITY_____ ZONE____ STATE_____

IT'S THERE IN HOURS...AND COSTS YOU LESS!

For additional information, use postcard facing back cover.

the Ames idea: through simpler diagnostics... standardized results... manpower savings

There is no panacea for those universal hospital problems—rising costs and shortage of skilled help. But for many hospitals, a step in the right direction has been adoption of the AMES idea: the simpler the procedure, the less chance for costly error in execution and interpretation.

With this idea in mind, AMES through research has pioneered and perfected a growing line of *standardized* diagnostic products. The most rigorous *quality control* during every phase of production assures the *uniformity* and *reproducibility* of results that hospitals require.

In routine urinalysis, AMES Reagent Tablets are so simple to use that untrained as well as trained personnel obtain the same dependable, standardized results. The newer AMES Diagnostics are based on an even easier "dip-and-read" technique. And from one to three determinations can be made with one reagent strip.

Since there is no preparation of solutions or clean-up afterward, and these tests are actually performed in seconds, skilled technicians are freed for more demanding tasks.

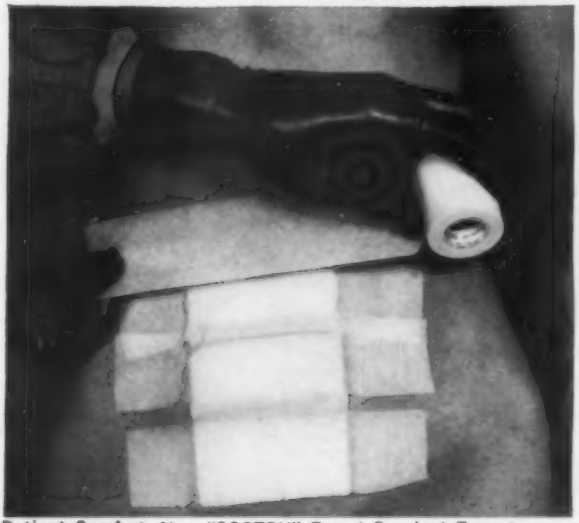
Your AMES representative will welcome an opportunity to explain how AMES Diagnostics can achieve standardized results and save time and money in your hospital.

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

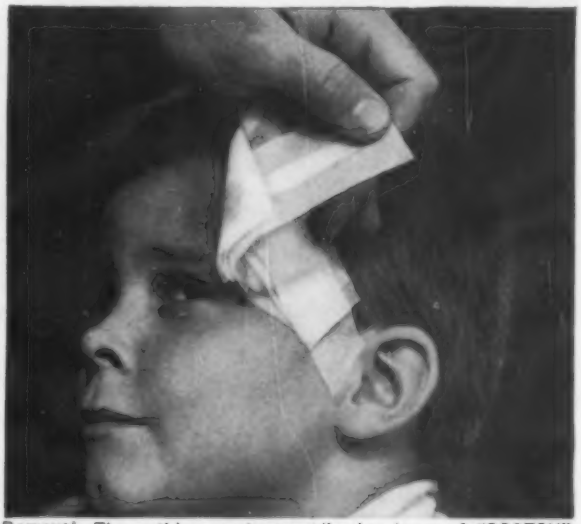
REAGENT TABLETS: ACETEST® · ALBUTEST® · BUMINTEST® · CLINITEST® · HEMATEST® · ICTOTEST® · OCCULTEST®

REAGENT STRIPS: ALBUSTIX® · CLINISTIX® · COMBISTIX® · KETOSTIX® · PHENISTIX™ · URISTIX®

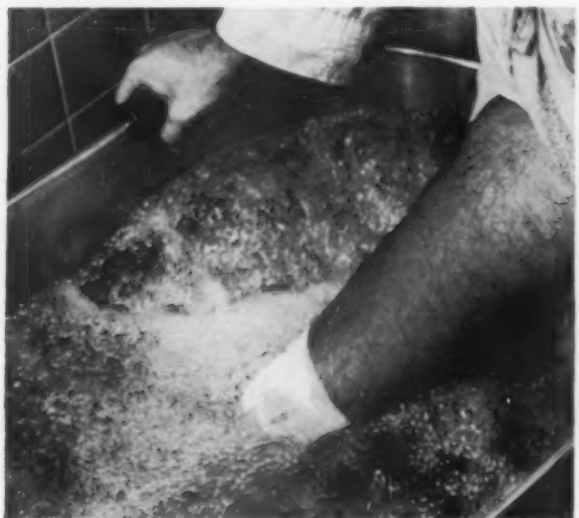
TOTALLY NEW SURGICAL ADHESIVE TAPE ANSWERS TRADITIONAL TAPE PROBLEMS



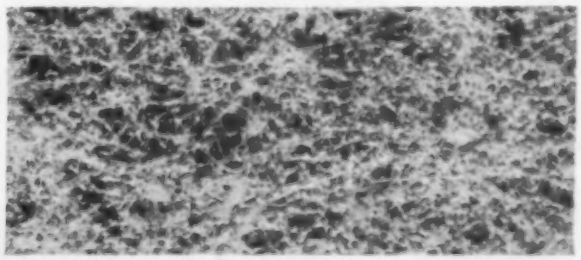
Patient Comfort. New "SCOTCH" Brand Surgical Tape is non-occlusive and physiologically inert. Prevents usual maceration . . . virtually eliminates chemical irritation, even in markedly tape-sensitive patients. It is cool, lightweight.[1]

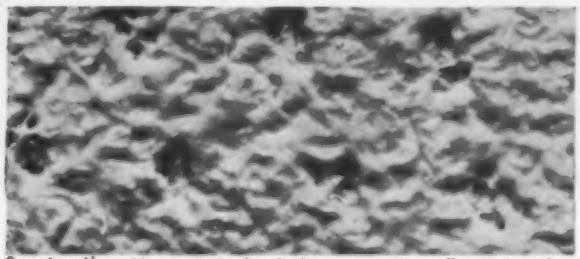


Removal. Tissue-thin copolymer adhesive layer of "SCOTCH" Surgical Tape clings firmly to skin, yet does not entrap hairs. Tape comes off quickly and easily without depilation. Leaves no dirty residue for time-consuming "clean-up."[1]



Dressing Changes. Sticks fast, even in sitz bath or whirlpool. Fewer changes are required. Yet this tape tears with ease; does not tend to stick to rubber gloves or instruments.[1] There is no shelf deterioration, no "end-of-roll" waste.





Construction. Macrophoto (top) shows new "open" construction of "SCOTCH" Surgical Tape that allows free air passage through **microporous** backing and adhesive. Perforated tape (bottom) is almost totally occluded by thick, potentially irritating mass.[1]

"SCOTCH" Brand Surgical Tape is available through your surgical supply dealer in usual widths. ½ to 3 in., 10-yd. rolls.

REG. U.S. PAT. OFF.

SCOTCH BRAND SURGICAL TAPE MICROPOROUS

No. 530

Application. Unlike conventional adhesive tapes, "SCOTCH" Surgical Tape does not slip or "creep," and ordinarily should be laid on without tension. Where tension is desired or anticipated, shear stress on the skin may be prevented by cross strips of "SCOTCH" Surgical Tape at the ends of primary application.

MINNESOTA MINING AND MANUFACTURING COMPANY
...WHERE RESEARCH IS THE KEY TO TOMORROW

1. Golden, T., A Non-Irritating, Multipurpose Surgical Adhesive Tape, Am. J. Surg. 100: 789,1960.

...Every Hospital Hand Gets Positive Protection By Pioneer

Hands at work in your hospital require protection of many different kinds. The complicated task of selecting the right glove for each hospital job is easy for us because we manufacture over 65 different styles of gloves for hospital, industrial and home applications. When you assign the task to us you save administrative time and assure yourself of ultimate glove economy throughout the hospital.

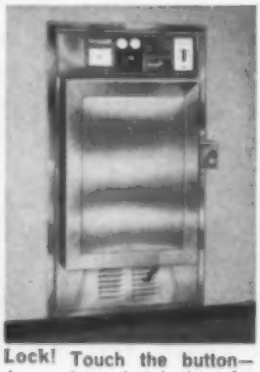
PIONEER
RUBBER COMPANY
350 Tiffin Road, Willard, Ohio

NEW Castle* POWERCLAVE with ELECTRILOCK DOOR

*Trademark Wilmot Castle Company

Open! Just push the button. Door swings out smoothly, silently—*effortlessly.*

Load! New LoadMaster Car and Safe-T-Lock Carriage handle larger loads, more safely.



Lock! Touch the button—door swings shut, locks safely, starts sterile cycle. No handwheel to wrestle with.

SAFER . . . Just a touch of a button closes and locks the door. Steam tight seal is automatic—regardless of the operator's strength. And three separate features make it impossible to open the door under pressure.

EASIER . . . No handwheel to struggle with. It's all automatic. Closing and locking the door, sterilizing, opening the door—it's pushbuttons all the way!

MORE CAPACITY . . . New design of vessel and car increases load capacity. And improved exchange of air and steam reduces cycle time—particularly advantageous with high vacuum techniques.

THAN EVER BEFORE! POWERCLAVE is the first major re-design of hospital sterilizers in forty years. Yet you can fit it right into your present sterilization program—for approximately the cost of a conventional autoclave! Write for POWERCLAVE literature.

Castle

WILMOT CASTLE COMPANY, 2012 E. Henrietta Rd., Rochester 18, N. Y.

Subsidiary of Ritter Company Inc.

TURN THE TABLES ON EXPENSES

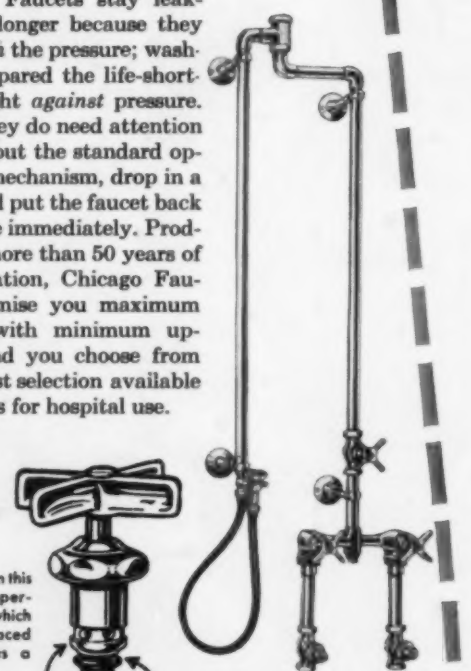
This newly-perfected Overbed Table is a perfect example of the way Royalmetal applies advanced engineering techniques to furniture design. Result: more beauty and better performance at reduced cost. Vanity top lifts and holds at any angle, thanks to new friction hinge. No ratchet boxes or parts to cause maintenance problems. Improved crank mechanism permits smoother, faster over-all height adjustment. Tops may be finished in wood grain or a variety of other colored laminates. The new Overbed Table Models, 2997 and 2998, will give your present decor a new interest and coordinate with other Royalmetal Hospital Furniture. For full information about this and other products in our complete hospital line, write ROYAL METAL MANUFACTURING COMPANY, Dept. 50-L, One Park Avenue, New York 16, New York. SHOWROOMS: New York, Chicago, Los Angeles, San Francisco, Seattle, Atlanta; Galt, Ontario.

Royal

ROYALMETAL

Why Chicago Faucets ask less "*time-out*" for repairs

Operating records prove it. Chicago Faucets stay leak-free far longer because they close *with* the pressure; washers are spared the life-shortening fight *against* pressure. When they do need attention just lift out the standard operating mechanism, drop in a spare and put the faucet back in service immediately. Products of more than 50 years of specialization, Chicago Faucets promise you maximum service with minimum upkeep. And you choose from the largest selection available of faucets for hospital use.



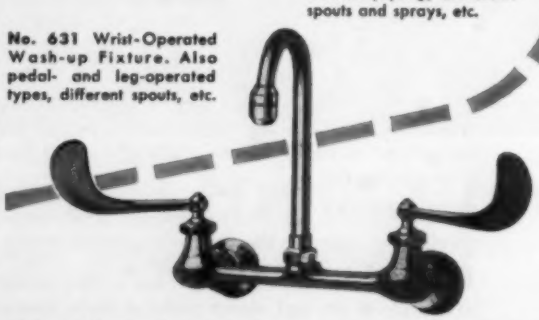
The secret's in this standard operating unit which can be replaced as easily as a light bulb.

SEAT

WASHER

No. 904 Bed Pan Flusher with integral vacuum breaker. Others with concealed piping, different spouts and sprays, etc.

No. 631 Wrist-Operated Wash-up Fixture. Also pedal- and leg-operated types, different spouts, etc.



The Chicago Faucet Co.
2712 N. Pulaski Rd., Chicago 39, Ill.

CHICAGO FAUCETS®
Last As Long As the Building

HERE'S HELP—
If you buy or specify faucets for hospital use write for complete catalog . . . or new Sketch Book of engineering data on special faucets.

Distributed through the plumbing trade exclusively

CUT DRAIN ON THE BLOOD BANK

Adrenosem®*

SALICYLATE

(Brand of carbazochrome salicylate)

Adrenosem helps conserve the patient's own blood. Adrenosem is accepted pre-op medication because it reduces the need for transfusion.

Adrenosem controls excessive capillary bleeding by decreasing capillary permeability while promoting the retraction of the severed capillary ends. Adrenosem's control of bleeding results in a clearer operative field. Reduction of postoperative ooze and seepage results in fewer calls on the nursing staff.

The safety and effectiveness of Adrenosem are proved by the administration of over 17 million doses in thousands of hospitals during the past 7 years. *There are no contraindications to Adrenosem at recommended dosage levels.*

SUPPLIED: *For I.M. injection only*—Ampuls: 5 mg., 1 cc., packages of 5 and 100; 10 mg., 2 cc., packages of 5. *For oral administration*—Syrup: 2.5 mg. per 5 cc. (1 tsp.), bottles of 4 oz. Tablets: 1 mg. (s.c. orange), bottles of 50, and 2.5 mg. (s.c. yellow), bottles of 50.

WRITE FOR DETAILED LITERATURE AND DOSAGE INFORMATION.

*U.S. Pat. Nos. 2581850; 2506294

THE S. E. MASSENGILL COMPANY

Bristol, Tennessee

New York • Kansas City • San Francisco

Armour and Company
announces a truly effective
germicide cleaner

ARMOSOL®

In extensive laboratory tests
against eight leading brands,
Armosol® out-cleans the best
cleaner, out-kills the best
germicide!

Armosol, the result of four years of exhaustive research, is a liquid synthetic cleaner and disinfectant that kills bacteria and deodorizes as it cleans. Armosol is particularly designed for hospital and institutional use where bacterial and fungal control are of prime concern.

Eight nationally advertised products of the Armosol type were thoroughly tested and compared with Armosol. The best *cleaner* of these fell far short of Armosol's efficiency. The best *germicide* was considerably less effective.

How it is used:

Armosol effectively cleans, sanitizes and deodorizes using the ordinary cleaning techniques, sponge, mop, floor machine, spray or flood. Armosol is also useful for cleaning refrigerators, stoves and other equipment as well as in the preliminary cleaning of surgical instruments.

It is economical:

Armosol is odorless, readily soluble in both hard and soft water, non-staining, and is gentle to hands. It does three jobs at once—cleans, sanitizes and deodorizes. At the recommended concentration of 1½ ounces per one gallon of water, Armosol will clean and sanitize approximately 1500 square feet of surface. One gallon of Armosol makes 85.3 gallons of solution, or enough to clean about 127,950 square feet at an average cost per day of 1¼¢ per patient.

Environmental Sepsis Control:

Armosol, together with Dial Bar, Dial (Hexachlorophene) Surgical Liquid Soap, and Velva-Soft-G (anti-bacterial fabric finish) for all laundered linens, now helps provide a practical program for environmental sepsis control in hospitals and institutions.

For technical information please write: B. J. Augst, Manager, Industrial Soap Division, Armour and Company, 1355 West 31st Street, Chicago 9, Illinois.

"In vitro" tests demonstrate Armosol's extraordinary effectiveness. The untreated plate above shows profusely growing Staphyloccus before treatment. The second plate clearly shows the complete inhibition of growth of S. aureus after application of Armosol at recommended use dilution.

Phenol coefficient: Using the A.O.A.C. Phenol Coefficient Method (revised—1955) Armosol has a guaranteed minimum rating of 14 against *S. typhosa* and 25+ against *S. aureus*. Although newer tests have revealed that the phenol coefficient alone is not an adequate criterion of disinfection, Armosol's rating is superior to any of the eight leading similar products.

Other tests: Using the Use-Dilution Confirmation Test (1953) which measures the kill at actual use levels, Armosol showed complete kill at 1:80 dilution against the test organisms, *S. choleraesuis* and *S. aureus*. The Chambers/Weber & Black Hard Water Tolerance Test (1958) was also used. Armosol destroyed 99.999% of these bacteria in water with a hardness of 500 ppm at the same dilution—and in just 30 seconds!

ARMOUR AND COMPANY **INDUSTRIAL SOAP DIVISION**

Hill-Rom No. 1100 Series Finished in No. 48 Honduras Mahogany

The No.11-69 All-Electric Hilow Bed is 39" wide—the ultimate in comfort. All standard operating features of the new all-electric hilow bed are included, insuring better patient care, reduced maintenance, simplified housekeeping. The end panels are laminated in Honduras Mahogany, with solid Mahogany hand-shaped moulding.

The No. 69 Hill-Rom All-Electric Hilow Bed is listed by U.L.Inc., and CSA for use with oxygen administering equipment.

A Distinguished Grouping for Your Distinguished Guests

In today's modern hospital it is generally recognized that the better income rooms should have a different, distinctive decor and furnishings. This Hill-Rom No. 1100 Grouping has been designed to meet these requirements.

This beautiful mahogany grouping combines 18th Century traditional styling with new freshness and restraint for practical application in the hospital. It appeals to those discerning patients who are accustomed to the best, the beautiful and the comfortable in their homes, and who will appreciate a hospital environment that reflects these qualities.

In creating this distinguished grouping Hill-Rom designers have provided many practical advantages that give the patient extra comforts and conveniences, and assure the hospital of minimum maintenance and cleaning costs.

Turn the page for additional views of this grouping.

HILL-ROM COMPANY, INC. · BATESVILLE, INDIANA

(Showing the No. 1126 Vanity Desk, No. 1108 Arm Chair and No. 1125 Straight Chair)

Another View of the No. 1169 Deluxe Private Room Suite

The beautifully designed vanity, chairs, and side pieces compliment the major items and make this a truly distinguished grouping for your distinguished guests.

LEFT:
No. 1104 Chest of Drawers with No. 1105 Mirror: The cases have solid mahogany legs and rails. Drawer fronts have a sparkling Fruitwood burl. The top is a custom designed Chinese Teacan pattern Formica—heat and stain-resistant. Hardware is typically antique, with brass pulls and brass plated caster yokes.

RIGHT:
No. 1108 Arm Chair—with No. 1137 End Table: All chairs in the No. 1100 grouping have solid mahogany legs, seat frame, back rails and stretchers. Top back rail of straight chair and side panel of arm chair have Fruitwood burl face stock. The arm chair is big, roomy and luxuriously comfortable.

For complete information on this de luxe private room grouping write or call—

HILL-ROM COMPANY, INC. · BATESVILLE, INDIANA

NEW! SIMONIZ LOCK & KEY*

PERMACRYLIC* FLOOR FINISH

CUTS MAINTENANCE COSTS IN HALF!

1 LOCK IT ON...FINISH LASTS AS LONG AS YOU WANT

2 UNLOCK IT...IT ZIPS OFF 4 TIMES FASTER

SCRUB IT *all* you want, because regular floor cleaners will remove only the dirt . . . not the finish. Simoniz Lock & Key keeps on shining—never needs buffing.

RECOAT IT whenever you want *without stripping.* It will not yellow, discolor or powder. Shine gets even better—protection lasts longer—with every coat.

LONGER-LASTING . . . provides protection and beauty longer than any product ever could before. Most durable, most easy-to-maintain floor finish ever formulated.

EASY TO REMOVE. Zips off in minutes with special Simoniz Lock & Key Remover when you want to strip it. Just mop the floor—no scrubbing machine needed—comes off 4 times faster than old-fashioned stripping methods.

*Trademarks of Simoniz Company

Great new chemical discovery cuts floor maintenance time and costs.

SIMONIZ®
FOR LONG WEAR—LESS CARE

CALL YOUR SIMONIZ DISTRIBUTOR, OR USE COUPON:

Simoniz Company (Commercial Products Division—Dept. MH-12)
2100 Indiana Avenue, Chicago 16, Illinois

Yes, I want to cut my floor maintenance time and costs. Without obligating me, give me the name of your nearest distributor and:

- ☐ Have him see me
- ☐ Arrange a demonstration of Simoniz Lock & Key
- ☐ Supply me with test materials

Name_____ Title_____

Firm Name_____

Street Address_____

City_____ State_____

For additional information, use postcard facing back cover.

the soap that

REDUCES SKIN BACTERIA— GIVES DEODORANT PROTECTION PEOPLE WANT!

Available in 1, 1¼ and 3-oz. sizes, unwrapped for greater convenience.

Developed by Colgate-Palmolive Research, new COLEO Anti-Bacterial Deodorant Soap with T.C.S.A. is winning tremendous acceptance with hospitals everywhere. A high-quality toilet soap, new COLEO—

- ★ **Used every day, it reduces skin bacteria . . . gives deodorant protection, too!**
- ★ **Inhibits bacteria on soap itself.**
- ★ **Lathers freely in hot or cold, hard or soft water.**
- ★ **Is non-toxic, non-irritating . . . has a pleasant fragrance.**
- ★ **Distinctive yellow color for ready identification.**

COLGATE PALMOLIVE CO. CP QUALITY PRODUCTS SINCE 1806 A SYMBOL OF QUALITY FOR OVER 150 YEARS

Associated Products Division

Colgate-Palmolive Company

300 Park Avenue, New York 22, N. Y.

not a general-purpose antibiotic

Albamycin is not a broad-spectrum antibiotic, recommended for routine infections. It is specific for staphylococci (including resistant strains), and its use alone should (with the exceptions listed below) be limited to those cases in which staph is known or strongly suspected to be the causative organism.

Albamycin*

Indications — Albamycin is indicated in the treatment of staphylococcic infections, particularly in patients sensitive to other antibiotics or in the infections in which the organism is resistant to other antibiotics and sensitive to Albamycin, and in urinary tract infections due to microorganisms resistant to other commonly employed antibacterial agents but sensitive to Albamycin — notably certain strains of Proteus.

Administration and Dosage — Capsules and Syrup: The recommended dosage in adults is 500 mg. every twelve hours or 250 mg. every six hours, continued for at least forty-eight hours after the temperature has returned to normal and all evidence of infection has disappeared. In severe or unusually resistant infections, 0.5 Gm. every six hours or 1 Gm. every twelve hours may be employed. The dose for children is 15 mg. per kilogram of body weight per day for moderately acute infections; this may be increased to 30 to 45 mg. per kilogram of body weight per day for severe infections. These doses may be administered on schedules similar to those for adults.

Parenteral: Intramuscularly—5 cc. of Albamycin solution may be used directly by slow injection deep into the gluteal muscle.

Intravenously — it is recommended that 5 cc. of Albamycin solution be diluted further with 250 to 1000 cc. of sterile injection solution of sodium chloride, Darrow's solution, or Ringer's solution and administered by intravenous infusion, or by diluting to a suitable quantity and administered by continuous drip infusion. **Do not use with dextrose solution.** When it is necessary to use a smaller volume intravenously, 5 cc. of Albamycin solution may be diluted to a minimum of 30 cc. with one of the above diluents and administered slowly over a period of five to ten minutes to avoid irritation of the vascular endothelium. The dosage for adults is 500 mg. Albamycin administered either intramuscularly or intravenously every twelve hours. For children with moderately acute infections, the dosage is 15 mg. per kilogram of body weight per day. The daily dosage should be administered in two divided doses at intervals of twelve hours. As soon as the patient's condition permits, parenteral Albamycin should be replaced with oral Albamycin therapy.

Side Effects — Albamycin is a substance of low toxicity but is capable of inducing urticaria and maculopapular dermatitis. Leukopenia, which was rapidly reversible, has been reported in approximately 1% of cases. All of these side effects disappear rapidly upon discontinuance of the drug. In a certain few patients, a yellow pigment has been found in the plasma. This pigment is a metabolic by-product of the drug which, however, may interfere with determination of bilirubin and icteric index. Its presence is not associated with abnormal liver function tests or liver enlargement.

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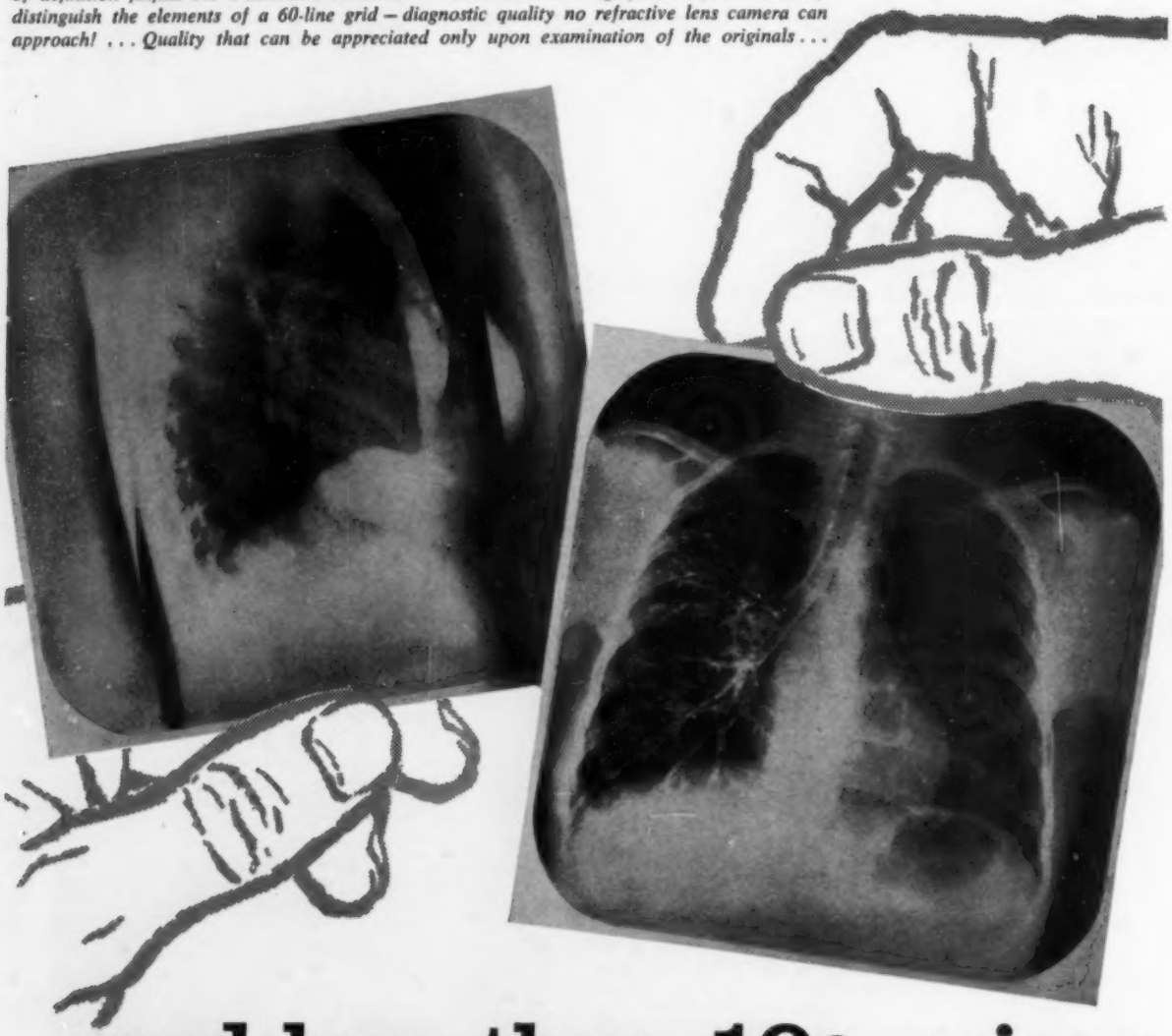

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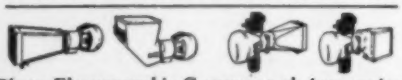

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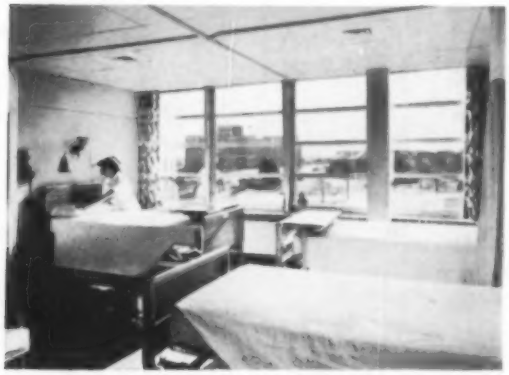

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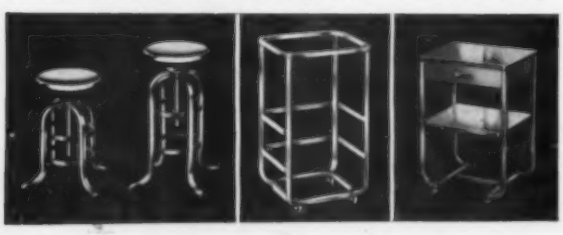

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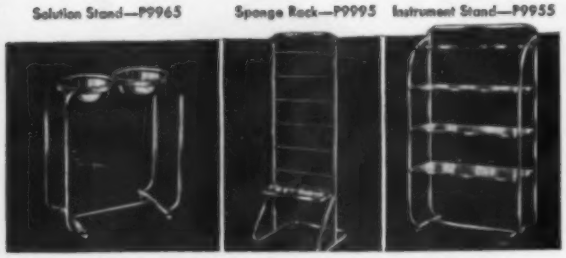

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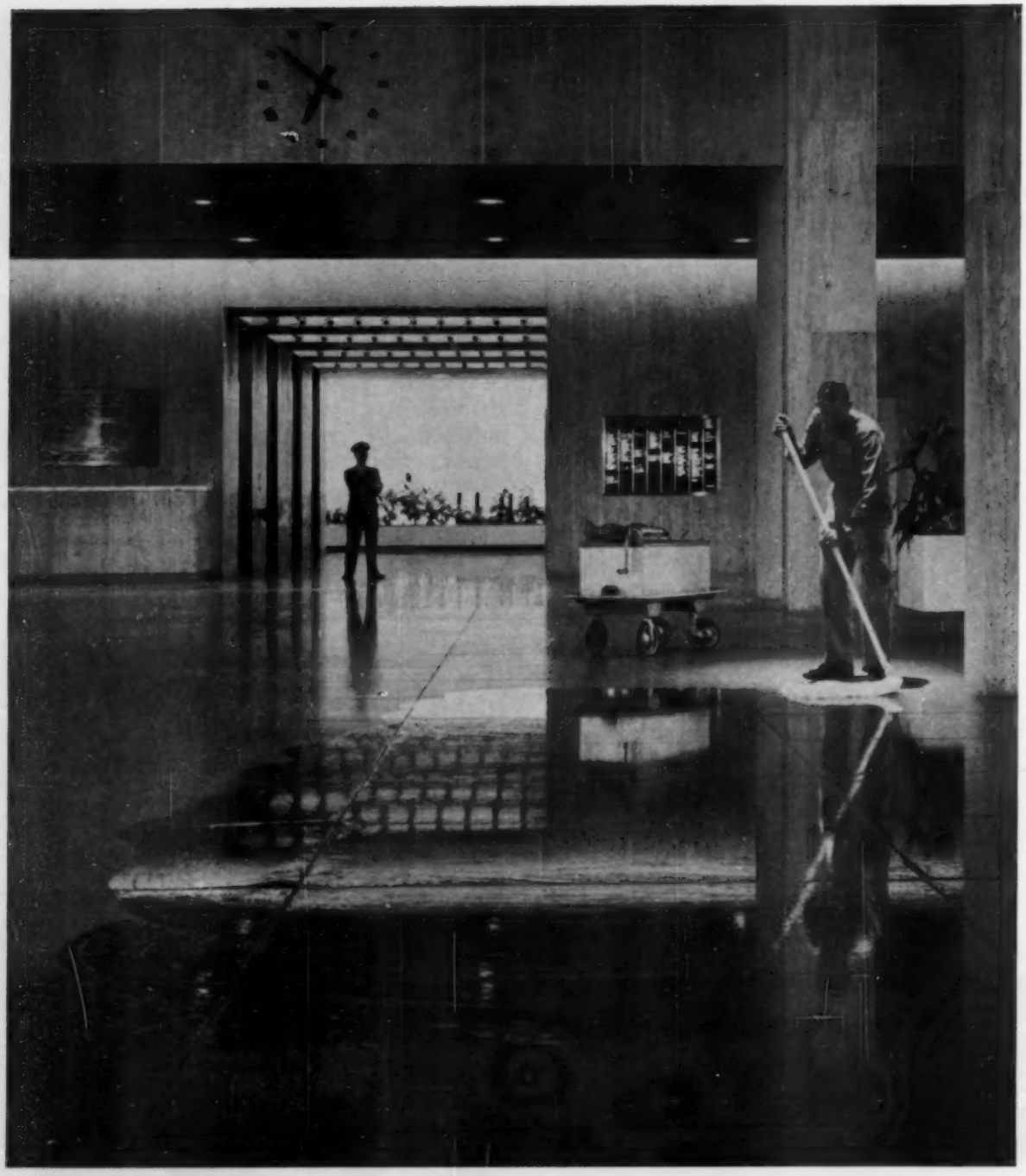

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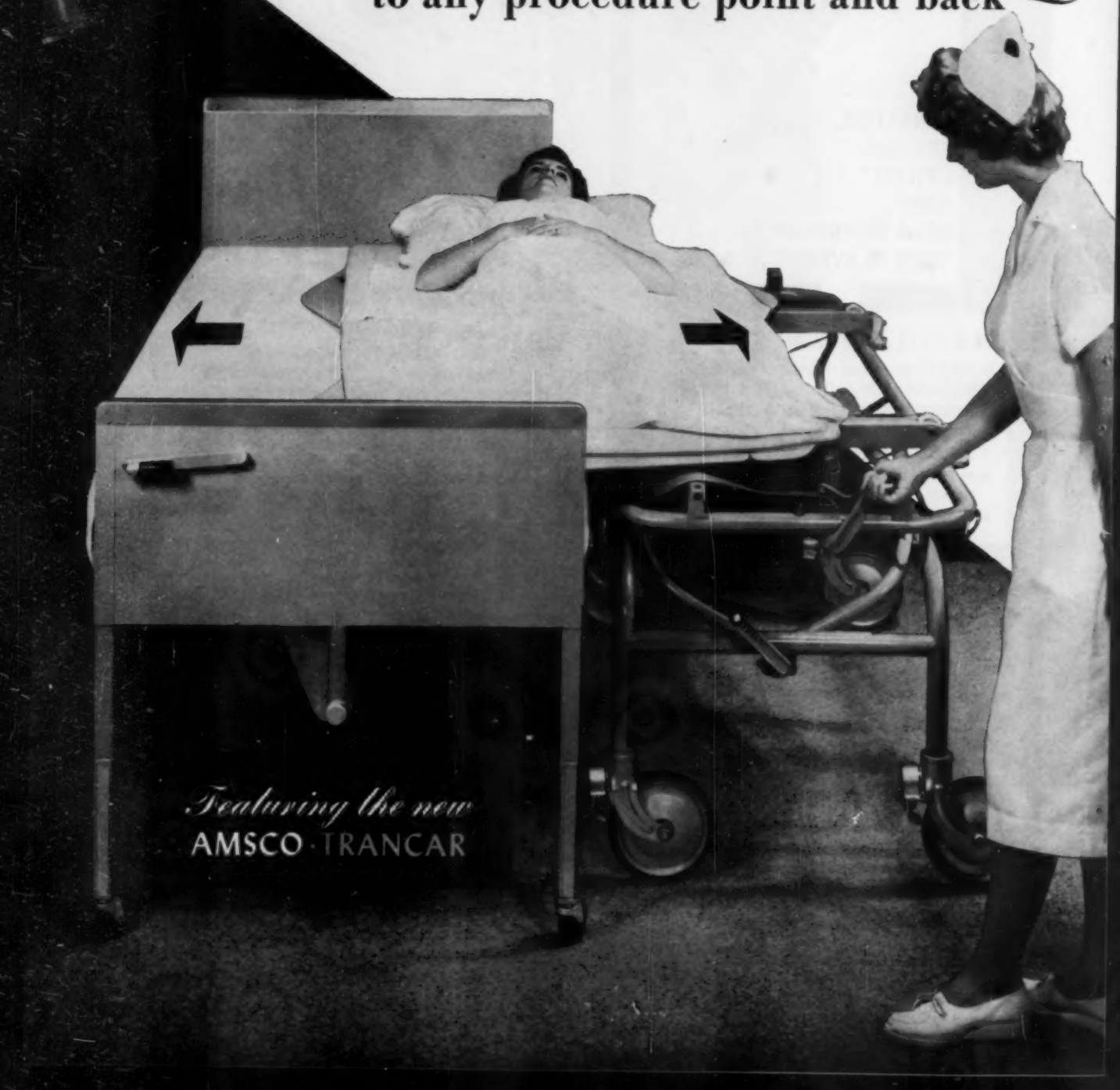

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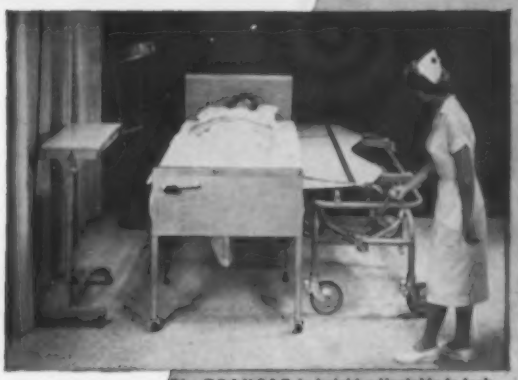

The TRANCAR is height adjustable to lock automatically to patient's bed while the nurse winds the low-friction top under the special pad.

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Automatic locking devices adapt the TRANCAR to most hospital beds and to virtually all operating, treatment or examining tables. The Amsco System is adaptable to *every* hospital. It provides substantial benefits to personnel and never-before-equalled comfort and protection for critically ill patients.

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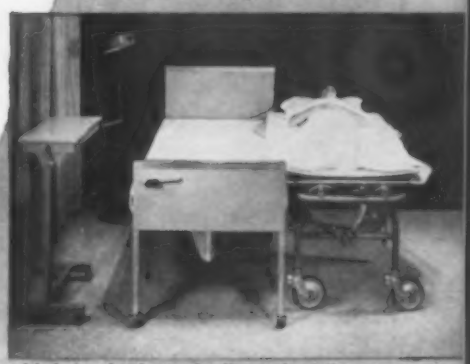

The pad is fastened and reversing the crank rotation moves the patient laterally, smoothly onto the TRANCAR.

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DECEMBER 1961

Time for Accommodation

FOR the last two years, headlines charging the ethical pharmaceutical industry with manifold sin have been a recurring political phenomenon, like riots in Algeria. Like the riots, the headlines haven't just happened; rather, they have been planned, and led, toward the accomplishment of a specific political goal. In this case the leader has been Sen. Estes Kefauver of Tennessee, chairman of the Senate Subcommittee on Antitrust and Monopoly, and the goal is legislation providing for almost total federal regulation of the pharmaceutical industry. Among those who have contributed to the massive records of the subcommittee are many able and honest leaders of both industry and government, only a few of whom, probably, would either go all the way with Senator Kefauver or stand pat with those industry spokesmen who insist that any change at all would be a disaster. Here, then, are the elements and the opportunity for honorable accommodation.

Among other things, Senator Kefauver's bill (S. 1552) would (1) empower the Secretary of Health, Education and Welfare to license all ethical manufacturers, inspect manufacturing plants, and certify the efficacy as well as purity and safety of drugs; (2) authorize Health, Education and Welfare to devise and maintain lists of generic names for all drugs and require manufacturers to include the generic name, in the same size type as the brand name, in all labeling and advertising; (3) require manufacturers to provide physicians with full information on the dosage, usefulness, side effects and other characteristics of their products; (4) diminish patent protection on new drugs and make licensing mandatory for qualified applicants; (5) limit patents to new drugs with "significantly greater therapeutic effect" than that of existing drugs, and (6) outlaw agreements settling interference claims by rival patent applicants.

Hearings on the bill before the subcommittee started last summer and are being resumed this month, with industry spokesmen scheduled to appear. Significantly up to now, even witnesses who were favorably disposed toward the bill have been notably shy about endorsing its most controversial provisions—those having to do with patent protection. Thus David Ladd, U.S. Commissioner of Patents, warned against "countervailing bad effects on the inventive motivation of the patent system," and the American Hospital Association, in a memorandum that was generally lyrical about other provisions, limited its comments on the patent sections to their effect on the hospital formulary system. Speaking for the American Bar Association, another witness, Joseph G. Jackson, Philadelphia patent attorney, opposed the patent provisions "because we'd expect special patent laws on eggs, milk and beer next." Patent lawyers also testified against the elimination of agreements settling interference claims, pointing out that such agreements have brought about rapid solution of patent problems, making new drugs available months or years before competing claims could be settled by the Patent Office, or in court.

While it seems plain that Senator Kefauver isn't going to get enough support to ensure serious consideration, let alone passage, of the patent provisions, it is possible that some of the other proposals might be negotiable, if not acceptable, to opponents of the bill. Certainly industry can't reasonably be expected to swallow the provision that generic names should be featured equally alongside brand names in labeling and advertising, a practice that would shake the foundations of brand identification on which the whole marketing structure rests—not just in the pharmaceutical industry but in American business generally. But some support might be found for a requirement that physicians should include generic names, along with brand names, in their prescriptions.

Another provision in the nobody-wants-it-but-Kefauver class is the one that would make H.E.W. responsible for devising and maintaining generic names. H.E.W. Secretary Ribicoff and the A.H.A., among others, said they would prefer to leave this responsibility in nongovernment hands. "We think it would be a mistake to overlook the Council of the United States Pharmacopeia, its various advisory boards, and the Council on Drugs of the American Medical Association, which have made a great and disinterested contribution to this field for the past many years," said the A.H.A.

Secretary Ribicoff also pointed out that the Food and Drug Administration doesn't need more legislation, but only more money, to carry out inspections of manufacturing facilities; it already has the authority. Some manufacturers might fear abuse of inspection and licensing privileges if this authority were made effective, but it can also be argued that reputable companies have nothing to hide and the system could operate to eliminate substandard manufacture.

The American Medical Association takes the position that only physicians in practice can determine the true value of a new drug, and it is hard to see how F.D.A. responsibility for efficacy as well as safety could be assumed without prolonged trials that would delay release of new agents beyond all reason, to the detriment of public health. Some observers have suggested the manufacturer might be required instead just to demonstrate that a new drug will do what he claims it will do—a fair demand that only trimmers would be likely to protest.

Nobody really objects to the requirement that physicians be given full information on the dosage, usefulness and side effects of drugs. Good physicians, good companies and good government can desire no less.

Pseudomonas Threatens To Become Major Infection Hazard in Hospitals

WHILE hospital infection committees are looking for reservoirs of staphylococci and devising methods of eradicating them, they would do well to keep an eye out for possible sources of other, equally virulent, organisms, notably *Pseudomonas aeruginosa* and other gram-negative bacteria, according to clinical and public health authorities.

Pseudomonas aeruginosa is almost the only one of nearly 150 species of this family that is definitely known to be pathogenic to human beings. Only within the last several decades have the lethal tendencies of this organism been clearly demonstrated. Until recently it was classified as nonpathogenic. Since 1949, however, reports in the medical literature indicate that antibiotic-resistant strains of pseudomonas have caused a more than four-fold increase in fatalities.

Medical and public health authorities are convinced that pseudomonas is involved in an alarming number of fatalities in hospitals, as evidenced by "a steady increase in deaths from pseudomonas since 1935" reported by one municipal hospital and the fact that the organism was involved in 21 fatalities in a children's hospital in 1957 as against two in 1952. However, no precise figures are available as to numbers of cases in all United States hospitals, the Public Health Service reports.

A special study made for a drug manufacturer offers a possible explanation for this situation. The study, which included only a small sampling, indicated that few nonteaching hospitals look for and recognize the presence and significance of cultures of pseudomonas "until the organism is practically staring us in the face," as one hospital resident put it. Teaching hospitals perform more cultures per bed than nonteaching hospitals do. However, not one of the hospitals surveyed, teaching or nonteaching, had pseudomonas data readily available or tabulated, research workers reported.

Anyone who is looking for pseudomonas will have no difficulty in finding it inasmuch as it is a frequent contaminant of human skin and flourishes in both water and soil. Nurses, aides and other personnel who have to handle contaminated articles such as bedpans, urine bottles, soiled linens, and instruments are likely to serve as carriers.

Pseudomonas is a more indolent organism than the staphylococci and doesn't sweep around the hospital with the same speed and violence. Once established, however, it seems to be transmitted easily from certain types of persons to others. Furthermore, it is highly resistant to most commonly used antibiotics.

The persons most likely to be attacked are the very young, the very old, and those with severe and debilitating chronic disease, according to Dr. Theodore C. Eickhoff, a member of the epidemiology service of the P.H.S. Communicable Disease Center in Atlanta. Premature infants, for example, are a natural target, and are in a vulnerable position because high humidity makes incubators a favorite lodging place for both pseudomonas and the other water-borne bacteria. An important group of patients at special risk from pseudomonas are those with burns; that organism is the commonest and most troublesome bacterial invader in such cases.

Pseudomonas is not a "particularly fastidious organism," Dr. Eickhoff points out. It needs only a little moisture to keep it healthy and happy although it lives only a short time without moisture.

Special attention, therefore, must be given by hospitals to the cleanliness of humidifiers, sinks, drains and air coolers. One infection of pseudomonas has resulted from the collection of stagnant water behind the screen of a faucet aerator in the nursery of a California hospital.

The stagnant water provided an ideal environment for the bacteria, and contaminated the water coming out of the faucets, the faucets themselves, the sinks and counters, and the sponges used to clean this equipment in the scrub sinks outside the nursery. After the aerators had been removed, cultures from inside the faucet lip and the water were negative for pseudomonas. After some months, however, cultures taken on the scrub sinks showed that the bacilli had turned up again, and a thorough cleaning of joints and fittings in sink pipes was required before cultures of these areas were once again negative.

The moral, public health officials believe, is obvious. An intensive cleaning now and then is not enough to control dangerous organisms indefinitely. All possible reservoirs of infection must be cleaned routinely, with no letdown in aseptic technic.

While pseudomonas is found oftenest in dirty areas, it also gets along nicely in liquids that are presumably sterile, including distilled water, antiseptic solutions, and ophthalmic preparations. It is not infrequently found in disinfectants which not only are completely ineffective in combating the organism but even permit its growth. One epidemic of pseudomonas septicemia was traced to cold sterilization of surgical instruments, for example.

High on the list of potentially hazardous reservoirs of pseudomonas are oxygen therapy equipment and anesthesia face masks.

Commenting on the problem of maintaining aseptic cleanliness of anesthesia masks, one executive housekeeper, who serves on the hospital infection committee, pointed out that "more danger lurks in the tubes and mouthpieces of anesthesia equipment than in or on anything Dr. [Carl] Walter has ever complained about." She added that medical anesthesiologists are more likely to be guilty of breach of technic than nurse anesthetists are. "They object to cleaning up their own equipment and they won't let anybody else do it for them."

Asked how hospitals can prevent the spread of pseudomonas infections, Dr. Eickhoff urged "rigid standards of asepsis, the judicious and conservative use of antibiotics, and plenty of handwashing."

"DPF Concept" Helps Predict Bed Needs

By grouping hospital beds into distinctive patient facilities (DPF), planners can utilize the laws of probability to determine the optimum number of beds needed in various hospitals and communities

Mark S. Blumberg, M.D.

BED needs are generally determined by dividing the average hospital census by some typical, desirable or average occupancy figure. Such methods, however, do not properly account for variations in effective capacity resulting from either the size of individual hospitals or the size and number of bed facilities within individual hospitals.

The procedure for estimating bed facility needs described here attempts to comprehend these factors and provides an over-all quantitative approach to the problem.

Introducing "DPF"

For convenience in caring for patients with similar needs, and for a variety of other reasons, the patient care areas for inpatients in a community tend to be grouped by one or more of the categories in Table 1.

A distinctive patient facility (DPF) may consist of one or many nursing units in a given hospital. Thus, three 15 bed pediatric wards in one hospital are equivalent to one 45 bed nursing unit, provided that any pediatric patient can equally well occupy any one of the 45 beds which is available. Such a unit is considered one 45 bed pediatric DPF. If, however, 15 of the beds are set aside for infants and the rest for other children, then there are two DPF's. Three 15 bed pediatric units in three different hospitals in a community would be considered as three DPF's unless the choice of which unit a patient entered was based entirely on the availability of space. More typically a patient would enter one unit in preference to another because of his doctor's staff privileges, or because he was medically indigent or because care better suited to his condition was available at one unit but not another. Thus a facility is considered as distinctive if it is used by only one corresponding distinctive type of patient under normal circumstances. Frequently several factors listed in Table 1 are combined to define a distinctive care area. (*Viz.*, the male, surgical, charity ward.) Planning for each class of patients is important because a bed available to one type of patient is of little value to another type.

The total of beds available to a community is not a meaningful measure unless all the beds are available to everyone. Devising a regional hospital plan can be logically divided into several phases.

The first one would be to determine the anticipated average load (census or bed-days) on a distinctive patient facility for any given population in the future. In estimating the future demands, several factors are or should be considered in addition to the population trends and trends in demands per capita. Services which are provided now but which should or would not be in the future must be subtracted while those not provided now which should be in the future must be added. Both of these corrections involve medical opinions and it is difficult to make such estimates. Consequently, despite their importance such considerations are often unwisely omitted.

Once the future average case loads of existing and possible DPF's have been arrived at, the problem of estimating the amount and type of facilities needed to care for the load still remains. The remainder of this paper is primarily concerned with this problem. Although consideration will be given primarily to estimating the needs for hospital beds, much that will be presented also holds true for other types of hospital services.

The concepts underlying the proposed procedure are outlined in the following quotation,[3] which summarizes information given elsewhere:[1,2]

"Beds which are unoccupied in a hospital are insurance against the risk of not having enough beds when the number of patients goes higher. The 'premiums' for this insurance are made up by the cost of having unoccupied beds and include uncompensated depreciation on the facilities, and the cost of staff who are partly idle while beds are unoccupied. The former is almost neglible while the latter is substantial.

"The 'benefits' of this insurance result in preventing the increased disability of patients which may result

TABLE 1 — Examples of Types of Distinctive Inpatient Care Facilities

1. By Patient Age
   - Geriatric
   - Adult
   - Pediatric
2. By Patient Sex
3. By Patient Religion
4. By Patient Race
5. By Patient Residence
6. By Procedure or Attending M.D. Specialty
   - Obstetric
   - Medical
   - Surgical
   - Psychiatric
   - Orthopedic
   - Gynecologic
7. By Length of Stay
   - Short (overnight)
   - Intermediate
   - Long-Term
8. By Size of Patient Room
   - Private
   - Semiprivate
   - Ward
9. By Level of Nursing Care Required
   - Intensive
   - Intermediate
   - Self-Help
10. By Source of Payment for Care
    - Patient (or his insurance)
    - Closed Prepayment Plan
    - Private Charities
    - Public Welfare
11. By Availability for Teaching
    - Teaching
    - Nonteaching

from a shortage of beds because of (1) the delay in admission of those needing hospitalization, (2) the necessity of placing a patient in a substitute or inadequate hospital facility, and (3) the premature discharge of a patient to make room for a new one."

In summary, too few beds result in increased health hazards while too many beds lead to higher dollar costs. Although there is no simple way to balance health costs against dollar costs so that an optimal number of beds can be planned, it is believed that such a procedure can and will be developed since it is basic to effective health planning.[4]

For the present, the following procedure is proposed, which it is believed will clarify much that relates to bed needs and will permit meaningful comparisons of relative capacity to be made between various hospitals and communities.

The Method

The number of beds is considered adequate (for a given average census of distinctive patients) when the distinctive facility is fully occupied (and unable to admit new cases) for a specified proportion of the time.

A quotation from the Oahu study[4] amplifies this point.

"The provision of enough facilities to give absolute protection for the largest conceivable patient load is not economically feasible because there is always the chance that some epidemic or other catastrophe will overload facilities that are more than ample for ordinary needs. The problem is rather one of determining what chance of overloading in a given service can be tolerated. The method developed in this study will indicate the degree of risk involved at various facility capacity levels for each of the several services. The final decision of acceptable limits in terms of bed capacities, however, must rest with those responsible for the community's health."

Empirically, it has been observed that clinical services that are filled to capacity between 1/100 and 1/1000 of the days are adequate in capacity. For some DPF, running out of beds 1/10 of the days may be acceptable; in others, one should be prepared for admitting new patients on all but one day per 10,000 or 100,000. The objective of this paper is not to gain acceptance of a given probability of a facility's being filled to capacity, but rather to demonstrate that two communities' facilities can be considered equivalent in amount when they are filled to capacity equally often.

As stated, a more formal method of determining the balance between over-capacity and under-capacity would be desirable. However, the proposed measure permits comparisons of numerical adequacy among diverse communities and hospitals.

For an existing distinctive patient facility one can count the number of days during a set period of time on which a given load was exceeded.* Such peak loads are a reflection both of the number of days on which observations were made as well as of the extent of day-to-day variation. As a convenience for smoothing and extrapolating data, it was observed that the frequency distribution of loads on various distinctive services was approximately log-normally distributed, particularly for the higher loads.[5,6,7] However, a more general method of determining the expected frequency of high loads when empirical data were not available was desired.

Unpublished studies* of data from hospitals in several communities[8,9,10,11,12] have indicated that daily (midnight) census figures on a DPF are generally Poisson-distributed.**

The Poisson distribution is a form of skewed bell-shaped curve in which the entire shape of the curve may be predicted when only the average is known. (For a fuller explanation of the distribution see a recent article by Thompson.[13]) This property is of interest since it permits us to estimate the proportion of times that a given

(*Continued on Page* 78)

*Several others have also indicated that case loads of various hospital facilities are Poisson-distributed. For the delivery suite, see Thompson,[13] and for the intensive care unit, see Flagle.[14] Various other applications of Poisson-distributed loads, particularly of outpatients, have been made by N.T.J. Bailey.[1,2,3]

**While this paper was in manuscript, chapter 20 of "Hospital Care in the United States"[20] was called to the author's attention. In this reference a normal occupancy rate was defined as "one at which the beds of a hospital are completely utilized only one or two days during the year, except during times of abnormal need caused by unusual events." The bed need was estimated by adding four (or three) times the square root of the average census to the average census. Although there is no mention of the Poisson distribution in this reference, it may well have been in mind since the square root of the average (or mean) is the standard deviation in the Poisson distribution. However, as indicated in this text, use of these square-root formulas give only approximations of the true Poisson distribution.

What Too Many or Too Few Beds Mean to a Community

Here, in some detail, are the consequences of too few and then of too many beds. If at a given time the number of beds for a distinctive group of patients should be too few, one of the following courses of action will have to be taken:
1. Admission of the patient will be delayed until a bed is available.

Delaying admission for a patient who requires an elective procedure does not in itself ensure that the patient will have a bed later. The patient for an elective procedure must not only be willing to wait, but must also be willing to enter the hospital on a day's notice when the unpredictable emergency load has declined. It is likely that this sudden entry is more inconvenient than the wait. For this reason the mere length of waiting for an admission is probably not as reliable an indication of the capacity of a facility as is the length of time that a waiting patient has between being assigned a definite date for admission and the actual admission date.

2. The patient will be admitted to a substitute facility, in lieu of the proper one.

Such a substitute facility can be either inadequately equipped, too distant from the patient's home or the doctor's office, or otherwise not be the facility of choice for a particular patient. The patient's home or a hospital corridor are examples of substitute facilities.

3. A patient already in the hospital will be prematurely discharged to make room for one who needs to be admitted.

The premature discharge of a patient is more than an inconvenience since it runs a definite risk of medical complications.

Each of these three alternatives results primarily in jeopardy to a patient's health rather than in economic loss. The acceptability of these courses depends a great deal upon local circumstances. For example, in England and elsewhere a delay of many weeks for a scheduled or elective operation is quite acceptable to the patient and doctor alike; in this country it would be considered intolerable. In some communities the patient and his doctor are indifferent to which hospital the patient is admitted, but in most of the United States it is important to be admitted to the hospital of the doctor's choice.

In contrast to these costs of insufficient number of hospital beds there are the costs of surplus or excessive beds in the community. These costs are largely dollar costs and are made up of several factors. The depreciation on the empty bed and idle equipment can be ascertained, although such data are not generally calculated. A recent report[17] in which systematic accounting procedures were applied to several southern hospitals indicated that total depreciation on buildings and equipment was about 5 per cent of total hospital expenses. Costs of this magnitude are certainly not trivial, but they suggest that the largest expense of an idle facility would be the idle staff. Data for 1960 from nonfederal short-term hospitals indicate that 62 per cent of hospital expenses are for payroll.[18] Although costs for depreciation on plant and equipment continue when a facility is idle, personnel costs do not necessarily continue. In fact, in many instances when the bed occupancy is low, the number of personnel on duty also declines, as, for example, on week ends, holidays and vacation periods.

Thus, one should not assume that low occupancy means idle personnel. Studies should be done on the daily staffing patterns of hospitals and these should be related to the daily census.

When considering idleness of employes due to variations in work load, there are in fact two important groups of employes in a given hospital.

Group I — Those working on distinctive patient facilities (*i.e.* virtually all personnel assigned to nursing units plus those in supporting services like the formula room, which serve patients on one DPF).

Group II — Those working elsewhere in the hospital (*i.e.* those in the kitchen, x-ray, laboratory, pharmacy, laundry, medical records, central supply and administration, including nursing administration).

The work load of Group I employes fluctuates as the load on their own distinctive patient facility fluctuates, while the work load of Group II employes depends on the work load in a larger facility — the whole hospital.

Data indicate[19] that salaries are about equally divided between those employes in Group I and those in Group II.

ELECTIVE ADMISSIONS ARE PROBABLY NOT

Fourteen Guides To Help Planners Plan

Here are some guidelines* based on the approach taken in this presentation for those interested in planning hospitals.

1. Take account of the various distinctive facilities given in Table I when inventorying a community's hospital resources.
2. Specify future needs as an average census for each actual or meaningful distinctive patient facility.
3. Determine whether daily load variations are Poisson-distributed in a greater variety of communities, hospitals and distinctive patient facilities.
4. Explore the possibility of utilizing more "buffer beds" in hospitals, which may be used by either of two types of distinctive patients and which may be alternately served by either of the two appropriate distinctive nursing stations concerned.
5. Give a fresh look to consolidating infrequently used specialty services, even if it means a specialized hospital.
6. Note that the technical side of hospital planning is a complex task; lay planning groups ought to obtain technical data as a basis for major policy decisions.
7. Conduct more research on the economics of striking a balance between the health risks of insufficient facilities and the dollar costs of excess facilities.
8. Develop additional means of reducing the costs of idle facilities by concurrently reducing the staff during idle periods.
9. Do not consider that smaller hospitals are necessarily mismanaged because their occupancy is low when the real reason may be statistical.
10. Encourage small facilities to refer admissions to other facilities when they are full, rather than to build more beds.
11. Note that a large hospital with many small specialized services may be forced to utilize its Group I employes (see page 77) inefficiently but it should do better with its Group II employes than a smaller hospital.
12. Consider two communities as numerically equivalent (in regard to hospital beds) when they run out of space equally often, not when they have the same average occupancy rates.
13. When talking about needless duplication, consider everything in a hospital not concerned with direct patient care, including some of the large supporting services staffed by Group II employes.
14. Remember that if you should fall sick you may be very grateful that your hospital has an appropriate empty bed. ■

*Many of these implications were given in an excellent and widely circulated report 14 years ago.[20] One wonders why such seemingly basic concepts still have not found wide application in hospital planning.

(*Continued From Page 76*)

case load will occur on a DPF when only the average case load of the facility is known.

Before proceeding, it may be well to mention some of the theoretical circumstances that govern whether or not the daily case load of a service will be Poisson-distributed.

The daily census may be expected to be Poisson-distributed when the occurrence of the condition requiring hospitalization is random, and only a small proportion of the eligible population falls sick at one time. Obstetrics is a good example, although induced labors on week ends may alter the distribution. Any service when admissions are governed by convenience, such as elective surgery, with heavy admissions early each week, is probably not Poisson-distributed. This would be particularly noticeable on a service such as eye or ear, nose, and throat, with such a preponderance of elective surgery. It was shown that the variance for all surgical census in Oahu was greater than would be expected for a service of that size.[6,7] Surgery as a whole may or may not be Poisson-distributed, since about half of general surgery is emergency and half is elective. A combined medical-surgical facility is likely to be virtually Poisson-distributed. It may be possible to deal with the surgical case load as Poisson-distributed emergency cases which are superimposed on an elective load which varies regularly by day of week.

Admissions cannot be random if a given DPF is frequently overcrowded. In such instances a certain number of days with very high loads cannot occur because the facility is often filled to capacity. For this reason, daily loads at facilities with long waiting lists, as is common in England, are probably not Poisson-distributed.

If the reason for hospitalization is epidemic or markedly seasonal, the average census may not be Poisson distributed. Distributions of this type might be treated as made up of two separate Poisson distributions, one for

POISSON-DISTRIBUTED

the epidemic season and one for the non-epidemic season.

The distribution will also not be Poisson if there was rapid growth of average census on a facility during the period of observation. Rapid growth leads to an excess number of both high observations and low observations for the average census observed during the period.

Theoretically, services on which the average stay is quite long (as in psychiatry) should also have Poisson-distributed daily censuses, provided the admissions are Poisson-distributed. In these instances, periods of observation greater than one year may be needed. However, such facilities are frequently overcrowded; hence they are not Poisson-distributed.

To the extent that daily case loads are Poisson-distributed, Table 2 can be used to give numerical estimates on a variety of planning problems involving combinations of distinctive services. This table is based upon the Poisson distribution.

It permits one to determine the bed complement required for a given average census to have the proportion of days that a DPF will be fully occupied either 1 day in a 100, or 1 day in a 1000. A number of examples follow to illustrate the use of Table 2. In Table 2 and the examples, the following symbols are used:

C = Bed complement.

A = Average census.

p = Proportion of time a facility is filled to capacity.

In the preparation of Table 2 the numbers for bed complement were rounded to whole numbers, since a hospital does not provide a fraction of a bed. Thus, for example, if a true value for complement was any number over 9, but less than or equal to 10, it would be given in the table as 10. Consequently curves which may be drawn on the basis of the data in Table 2 may not be smooth, particularly for small values of A. ■

(See next page for examples of the use of Table 2. Bibliography for this article appears on page 170.)

Table 2—These Data Help Answer Bed Need Problems

(With a given average census (A), it is possible to determine the number of beds (C) that will result in a completely occupied facility an average of 1 day in 10, 1 day in 100, and 1 day in 1000.)

Average Census (A)	NUMBER OF BEDS (C) 1 Day in 10 (p = 0.1)	1 Day in 100 (p = 0.01)	1 Day in 1000 (p = 0.001)
1	3	5	6
2	5	7	9
3	6	9	11
4	7	10	12
5	9	12	14
6	10	13	16
7	11	15	17
8	13	16	19
9	14	18	21
10	15	19	22
11	16	20	24
12	18	22	25
13	19	23	26
14	20	24	28
15	21	26	29
20	27	32	36
25	33	38	43
30	38	44	49
35	44	50	56
40	49	56	62
45	55	62	68
50	60	68	74
55	66	74	80
60	71	80	86
65	75	85	92
70	82	91	98
75	87	97	104
80	93	103	110
85	98	108	115
90	103	114	122
95	109	119	127
100	114	125	133
120		147	156
140		169	179
160		191	201
180		213	223
200		235	245
250		288	301
300		364	377
400		448	465
500		552	572
600		658	679
700		763	786
800		867	890

Source: Derived from data in References 14, 18, 19

Results materially different from the above occur when the square-root approximations given in Reference 26 (page 170) are employed. For example, using the formula $C = A + 3\sqrt{A}$, p = 0.01 when C is 10 and p = 0.002 when C is 100. When the formula $C = A + 4\sqrt{A}$ is used, p = 0.001 when C is 10 and p = 0.0001 when C is 100. Thus the probability of a full facility varies not only with the square-root formula used, but also with the size of the facility.

These Examples Show How To Use the Table

EXAMPLE 1

The Problem: A 33 bed pediatric unit with an average census of 25 is filled to capacity 1/10 of the time. How many beds are needed to reduce the proportion of time that the facility is filled to 1/100 of the time; to 1/1000 of the time?

The Answer: Entering Table 2 in the "A" column on the "25" average load line we see that 38 beds are needed to reduce the proportion of time the facility is filled to capacity to 1/100, and 43 beds would be needed to reduce it to 1/1000 of the time.

EXAMPLE 2

The Problem: A hospital now has a 32 bed medical ward with an average census of 20 and a 26 bed surgical ward with an average census of 15. Table 2 indicates that each of these services are filled to capacity 1 day out of 100. How many beds would be needed to give the same protection against overload if the medical and surgical beds were combined?

The Answer: The combined average census would be 35 (*i.e.* 20 plus 15). A total of 50 beds would suffice, instead of the 58 now needed by the separate services.

These data also suggest another economical bed configuration. It might be desirable to have the medical and surgical beds predominantly on distinctive facilities to permit specialization of nursing care; however, if a small number of beds between the two facilities were dual-purpose, that is, usable by either medical or surgical patients when needed, then the total bed need could be reduced. With these dual-purpose or buffer beds the total bed need would fall between 58 beds (the situation with no buffer beds) and 50 beds (the situation with all buffer beds). A more precise means of determining the influence of buffer beds on total bed need is under study. It should be noted that the major advantages of buffer beds can only be realized if they are located so that nurses from each of the appropriate nursing stations can care for their corresponding patients in the buffer zone.

EXAMPLE 3

The Problem: A network of neighborhood hospitals each with 24 general purpose beds has been proposed by Atomedics of Alabama.[4] What will the average census of these hospitals be if they are to be filled to capacity 1 day in 100?

The Answer: Table 2 indicates the average census will be 14 for a hospital with a 24 bed complement.

EXAMPLE 4

The Problem: If a community has an average census of 140 short-stay patients, how many beds will be needed if all services were provided on 24 bed complement units which were filled to capacity 1 day per 100? How many beds would be needed if the average census was served by one hospital with general purpose beds instead?

The Answer: Ten 24 bed hospitals (each with an average census of 14) or a 240 bed total would be required with small Atomedic hospitals. The bed complement of a single hospital with equivalent capacity would be 169 beds. Thus 40 per cent more beds would be required in the community served entirely with 24 bed hospitals than in one served by a single hospital with general purpose beds. The increase in operating costs of the smaller units due to their erratic loads and the idle personnel probably would not be offset even if the small units cost nothing to build.

EXAMPLE 5

The Problem: A hospital maintains one set of facilities for its clinic or teaching patients and one for its other patients. The average census is as follows:

	Private	Clinic	Total
Medical-Surgical	200	50	250
Pediatric	30	20	50
Obstetric	20	20	40

How many beds are required to prevent overloads more frequently than 1 day per 100? How many would be needed if clinic and private cases were to be combined?

The Answer: The bed needs are derived from Table 2.

	Beds Needed If Separate		Beds Needed If Combined
	Private	Clinic	Private and Clinic
Medical-Surgical	235	68	288
Pediatric	44	32	68
Obstetric	32	32	56
	311	132	
Total if separate	443	Total if combined	412

on Page 79 To Help Determine Bed Needs

This example could just as well be applied to a community in which there is a county hospital for indigents and a hospital for all other patients; it also applies to communities or hospitals where separate facilities are maintained for Negroes and whites.

EXAMPLE 6

The Problem: A newly planned hospital is expected to have the following average case loads on distinctive services:

Adult Medical-Surgical	100
Pediatric	10
Obstetric	10

There is a possibility that an intensive care unit will be built at the hospital; it is expected to have an average census of 5 (drawn from the adult medical-surgical service). If each of the facilities is not to be full more often than 1 day per 100, how many beds are needed without an intensive care unit? How many with an intensive care unit?

The Answer: Table 2 indicates the following:

	Average Census	Bed Need
Without Intensive Care Unit		
Adult Medical-Surgical	100	125
Pediatric	10	19
Obstetric	10	19
	120	163
With Intensive Care Unit		
Adult Medical-Surgical	95	119
Intensive Care Unit	5	12
Pediatric	10	19
Obstetric	10	19
	120	169

Thus a total of 6 more beds will be needed with the intensive care unit.

EXAMPLE 7

The Problem: Given a community with 5 obstetric facilities, each with an average census of 11, which are each filled to capacity 1 time in 100, how many fewer obstetric beds would be needed if there was one consolidated obstetric facility whose chance of being filled was 1 in 100?

The Answer: Each of the present facilities now requires a complement of 20 beds. (Enter the 1/100 column of Table 2 opposite an average census of 11.) The total beds needed are 100 (or 5 times 20). In a single consolidated facility with an average census of 55 (5 times 11) the corresponding beds needed for 1/100 protection is 74. The net saving would be 26 beds (*i.e.* 100 less 74).

EXAMPLE 8

The Problem: A large city has newborn nurseries in 34 hospitals, with average censuses distributed as follows:

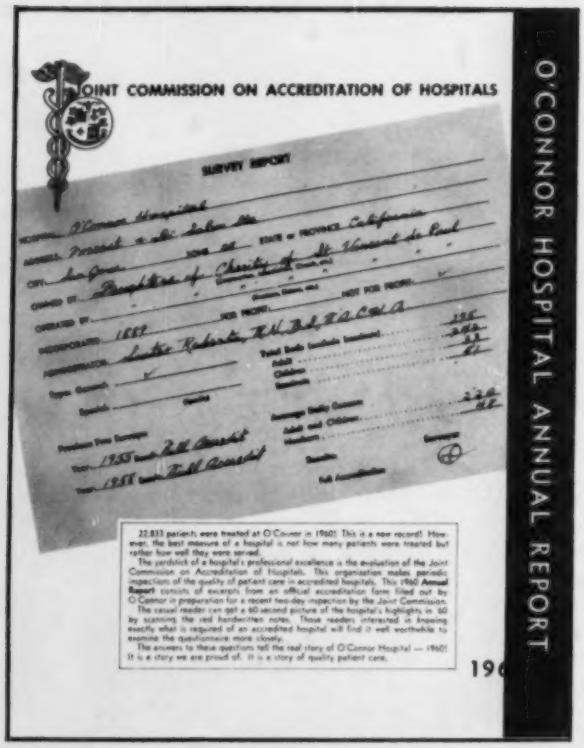
Number of Hospitals	Average Newborn Census in Each Hospital	Total Newborn Average Census
10	10	100
10	20	200
10	30	300
4	50	200
34		800

Each hospital has an infant formula preparation room and wishes to have the load for its formula room (and staff) exceed its capacity only 1 day per 100. For how many newborns must this city's formula rooms as a group be prepared?

The Answer:

Number Hospitals	Average Newborn Census in Each Hospital	Number of Newborns for Which Capacity Is Needed Each Hospital	Entire Group of Hospitals
10	10	19	190
10	20	32	320
10	30	44	440
4	50	68	272
			1222

Thus the city as a whole would have to have milk formula preparation facilities to be able to care for 1222 babies per day. The number of infants, not the number of bottles of formula, is the proper basis for estimating the variance since the number of bottles depends on the number of infants. (This is an example of a Stuttering Poisson distribution.[10]) In a similar fashion the number of meals served or laboratory tests done is also related to the daily census or admissions.

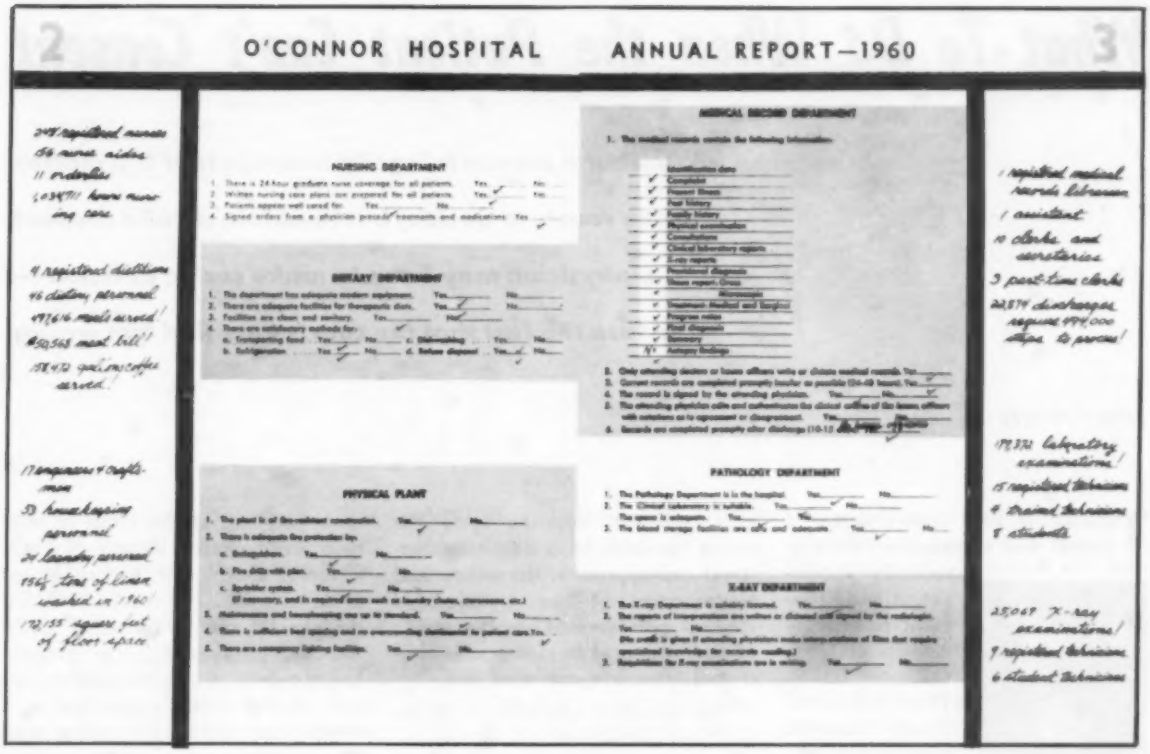


Cover of O'Connor Hospital report explains the importance of the use of accreditation as a means of evaluating care given patients.

Opposite page: First two pages of O'Connor Hospital's report show how various departments meet standards set by accreditation commission.

Annual Report

This annual report utilizes an accreditation evaluation form to tell the hospital's story in a bright, lively fashion that compels people to read it and helps them understand why accreditation is valuable


O'CONNOR HOSPITAL ANNUAL REPORT—1960

NURSING DEPARTMENT

DIETARY DEPARTMENT

MEDICAL RECORD DEPARTMENT

PHYSICAL PLANT

PATHOLOGY DEPARTMENT

X-RAY DEPARTMENT

Gives Credit to Accreditation

CITIZENS of San Jose, Calif., are probably better informed than most lay people as to the meaning, significance and value of the Joint Commission on Accreditation of Hospitals.

This is because O'Connor Hospital elected to make its 1960 annual report a reproduction of the official accreditation form filled out in preparation for inspection by the Joint Commission.

"It has always seemed to us that one of the major benefits of accreditation is lost if the man in the street or the patient in the hospital bed does not have a practical knowledge of accreditation," says Sister Roberta, administrator. And, she adds, very few do.

The annual report is admirably designed to combat this lack of understanding and to give the lay reader a truly comprehensive picture of O'Connor Hospital, its activities and services.

"We felt the layman would feel that, perhaps for the first time, he was being taken behind the scenes and was being treated as a 'professional,'" Sister Roberta says of the purpose of the report.

"In essence, we attempted to accomplish two goals with a minimum of expense: (1) explain accreditation in specific and graphic terms, and (2) report to the public on the activities of the hospital during the preceding year." ■

What To Do When the Patient Can't Consent

Whether a person is legally incompetent is a matter for the courts to decide, but to obtain a valid consent a physician may have to make such a decision—and face the fact that the courts may find him wrong

John F. Horty

THERE is little question that a person who is insane or otherwise mentally incompetent cannot legally consent to medical or surgical treatment. Therefore, no difficult hospital consent problems exist when a patient has been judicially determined to be mentally incompetent. The patient's consent is insufficient; consequently, consent of the patient's legal guardian or the person authorized by statute to consent for an incompetent must be obtained.

John F. Horty

In certain states, such as *North Carolina*, statutes specify this consent procedure. Where no such statute exists, or in the absence or unavailability of a guardian, a court of competent jurisdiction can authorize the required medical treatment.

Many general hospitals encounter the problem of obtaining a valid consent for incompetents only with respect to persons who have not been judged legally incompetent. Whether the consent of such a patient is legally sufficient depends upon the extent to which he is able to understand and appreciate the nature and consequences of the contemplated medical procedure. Thus the ability of such a patient to give a valid consent is often a question of fact.

The attending physician is in the best position to make this determination. In any instance where the physician doubts the patient's capacity to consent, the consent of the nearest relative or of that individual charged by statute with the duty of support, if the patient is a minor, should be obtained. In any event the patient's own consent should also be solicited and procured.

If time permits, the court should be asked to rule on the patient's capacity to consent.

In a *California* case, the court held that where an adult was incompetent and had no legally appointed guardian the right to consent to medical treatment was with the parent who was legally responsible for maintaining the incompetent. The court also stated that in the absence of statute, the general order of preference for obtaining consent would be spouse, parent, sister or brother, uncles, aunts and grandparents.

In a *New York* case, a surgeon was held responsible for an abortion performed upon a mental defective, committed to a state hospital, who became pregnant as the result of relations with another inmate. No one, including the patient, had consented to the abortion. The court stated that the plaintiff was incapable of giving consent; consequently, the surgeon had the duty of obtaining either consent of the patient's guardian or a court order before proceeding with the abortion.

A similar problem can occur when a sane patient is temporarily incapable of understanding the nature of the proposed treatment, such as when he is under sedation or has suffered an injury that places him in a state of shock or of temporary mental incapacity.

Since this is a relatively frequent occurrence, the hospital should always be certain that a patient normally competent to consent is actually competent at the time consent is given. If he is not competent, his nearest relative should sign the consent form. If relatives are unavailable and speed is required, the situation can be treated as an emergency.

If a patient is conscious, mentally capable of consent, and does consent, the consent of the patient's spouse is not necessary. In fact, a surgeon who operates solely upon consent of the spouse, and without the consent of the patient, could be held liable in a suit by the patient. However, in

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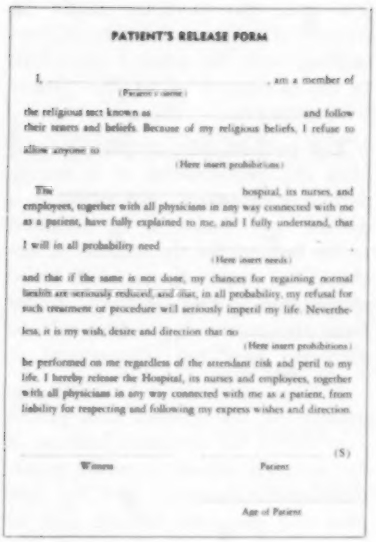
John F. Horty is director of the Health Law Center at the University of Pittsburgh.

This is the sixth article in a series on consent. The first appeared in the July issue.



PATIENT'S RELEASE FORM

I, _____, am a member of
(Patient's name)

the religious sect known as _____ and follow their tenets and beliefs. Because of my religious beliefs, I refuse to allow anyone to _____
(Here insert prohibitions)

The _____ hospital, its nurses, and employees, together with all physicians in any way connected with me as a patient, have fully explained to me, and I fully understand, that I will in all probability need _____
(Here insert needs)

and that if the same is not done, my chances for regaining normal health are seriously reduced, and that, in all probability, my refusal for such treatment or procedure will seriously imperil my life. Nevertheless, it is my wish, desire and direction that no _____
(Here insert prohibitions)

be performed on me regardless of the attendant risk and peril to my life. I hereby release the Hospital, its nurses and employees, together with all physicians in any way connected with me as a patient, from liability for respecting and following my express wishes and direction.

_____ (S)
Witness Patient

_____
Age of Patient

This type of release form should be used when a patient refuses to permit a certain procedure or treatment. While the form at left is specifically designed for the patient who objects on religious grounds, it can be adapted to different circumstances.

cases of emergency, or where a patient is unconscious or mentally incapable of consent, the spouse is the logical next of kin from whom consent should be obtained.

A recent *Missouri* case places upon the physician the duty of seeking out members of the patient's family when the patient, while in great pain or under sedation, refuses to permit needed treatment. Previous cases placed such a duty upon the physician only when the patient was unconscious and thus unable to determine for himself whether or not he would undergo treatment. This decision requires the physician to determine whether a conscious, objecting patient is temporarily incompetent. If so, the family must be advised and its consent to treatment solicited.

The rule stated in the above case places the physician and hospital in a quandary. If the physician relies upon the patient's refusal of treatment and the patient was incompetent at the time, the physician would be guilty of malpractice in failing to advise the family of the necessity for treatment. If the patient is later proved to have been competent at the time of his refusal, and the physician has relied upon the consent of the spouse or other members of the family for authority to treat the patient, the physician may be found to have committed an assault and battery.

This would be so because no one has the authority to consent for an adult in possession of his mental faculties. Thus, although this rule is primarily intended to protect the patient when he is unable to determine what is best for himself, in practice it may place an impossible burden on the attending physician. The best advice for a physician or hospital in such a dilemma is that possible liability for assault and battery is a much smaller risk than liability for malpractice. Consequently, the physician should proceed with treatment after obtaining the consent of the spouse or some member of the family if he doubts the patient's competency. Such a situation would not normally involve the hospital in possible liability, unless it is clear that the physician is treating an objecting patient who is obviously in full possession of his mental faculties.

Consent of the spouse as well as the patient is recommended only in those cases where the contemplated procedure will affect the reproductive ability of the patient. In such an instance it is possible, though unlikely, that a court will hold that the spouse has an interest in the reproductive ability of the partner that is recognized by law.

Nor does failure to get the husband's consent relieve him from liability to pay the hospital charges for an operation on his wife to which she has consented. It should be noted generally in connection with operations on married women that, in some jurisdictions, if the wife has a cause of action against the physician or hospital for battery the husband may also have a cause of action for infringement on his right of consortium and for loss of services.

It should be stressed that an adult patient who is conscious and mentally competent has the right to refuse to permit any medical or surgical procedure. This is so whether refusal is founded upon fear, religious belief, lack of confidence in the contemplated procedure or the physician involved, or mere whim. Every person has a legal right to refuse to permit a touching of his body, and failure to respect this right will result in liability for assault and battery.

Refusal of a patient to consent to any treatment stands upon the same legal ground as an expressed prohibition of a certain specific treatment or procedure, and the physician is liable if he proceeds without the patient's consent.

A hospital owes its patients the duty of using reasonable care to protect them from a touching to which they have expressly refused to give consent.

If a patient refuses to sign a con-

sent form for a contemplated procedure, or communicates his refusal of consent to the hospital's attendants or nurses, most courts would find that the hospital has received such notice of the patient's refusal to consent as to raise a duty on the part of the hospital to prevent the procedure from taking place within its walls.

It is recommended that no elective procedure be performed within the hospital if a patient has expressly refused consent. The hospital and attending physician should render the best care possible under the circumstances, and the patient's refusal to consent should be noted upon the medical record.

In such cases the patient should be required to execute a release so that proof is available that the physician used due care in recommending the proper treatment for the patient and that the hospital attempted to render proper care.

Although an adult patient in full possession of his faculties has the right to refuse treatment after a reasonable explanation of its necessity, and such refusal is a complete defense to a physician accused of negligence in not giving that treatment, whether treatment was ever offered or refused is a question of fact which the jury must determine.

In the *Missouri* case previously discussed in this article, the court stated that advice given to a patient unable to comprehend it because of pain is no advice at all. The court held that if the patient refused treatment because he was incapable of understanding, but urgently needed the treatment advised, and the doctor knew or should have known of the patient's incompetency, the duty of the physician is not ended.

Depending upon the facts of the case, specifically the seriousness of the need, or the urgency of the situation, or perhaps the time and interval of the patient's mental incapacity, the physician may have a duty to communicate with the spouse or other members of the family who are available and competent to advise or speak for the patient. Or, the physician might have a duty to take other steps to help the patient understand the need for certain treatment. Failure to do so might well constitute negligence on the part of the physician. As an extension of the rule in this case, the physician might be considered to have the duty of proceeding with the needed procedure in an emergency when the patient is incompetent.

The patient may specifically prohibit the performance of a certain part of a procedure. For example, a patient may desire to be admitted to the hospital for the delivery of her child, but expressly prohibit blood transfusions during delivery. Under these circumstances, the hospital and physician have two alternatives:

1. They can refuse to admit the patient on the ground that proper care cannot be rendered because of the patient's refusal to permit procedures and treatment which the hospital and physician believe may be necessary for the preservation of life. No legal liability will result from a refusal to admit such a patient so long as the refusal does not take place in an emergency situation.
2. The hospital can admit the patient and offer such limited services and procedures as the patient permits.

If the patient is already admitted to the hospital when a refusal to consent becomes known, a different legal situation ensues and the hospital must adopt the second alternative.

The hospital owes a greater duty to a patient than to a prospective patient and must render whatever care is possible under the circumstances. Whenever alternative two is adopted, the patient should be required to execute a release stating that he understands the risks attendant upon his refusal to permit a portion of the necessary treatment and that he assumes such risk.

The release form (see illustration on page 85) is drawn specifically for use in circumstances where the patient's refusal to consent is based on religious beliefs. However, with minor changes it can be used in any situation where consent to treatment is refused. This release will protect both physician and hospital. Requiring the execution of a similar release by the patient's spouse or nearest relative provides further proof that the care furnished, although not the complete care called for by the patient's medical condition, was in accordance with the wishes and desires of the patient. ■

Superintendent's Duty for Proper Care of Patient Affirmed by Washington State Supreme Court

OLYMPIA, WASH. — The state supreme court here recently upheld a $10,000 jury verdict in Pierce County superior court in a civil action against the superintendent of Pierce County Hospital.

The suit was brought for the benefit of the children of a woman patient who committed suicide in the hospital by strangling herself with plastic tubing. She had been admitted to the hospital after attempting suicide.

In its decision, the state supreme court placed reliance upon a state law that provides: "The general superintendent shall be the chief executive officer of the hospital or institution and shall perform all administrative services necessary to the efficient and economical conduct of the hospital or institution and the admission and proper care of persons properly entitled to the services thereof. . . ."

The court held that it was the duty of the superintendent to see that patients were properly cared for and, even though he did not have personal knowledge of the fact that the deceased had become a patient and was in need of special care, it was still his duty to see that any and all patients had the proper care.

The court relied to a great extent on the case of Ulvestad v. Dolphin, 152 Wash. 580, which was an action for false arrest. In this case the chief of police was held liable although he had no knowledge of the arrest of the plaintiff or of his incarceration, but was liable because the city charter provided that he was keeper of the city prison. ■

How Good Are Master's Degree Programs?

A minority report on the graduate programs in hospital administration suggests that while the concept of graduate education for administrators is laudable, programs are deficient in some areas

Frederic C. LeRocker

THE lure of a doctoral program in hospital administration is potent. For the educator in the field, it will give academic legitimacy to a preparation that is so frequently seen as a narrow specialization, if not an outright vocational training. The practitioner will have the right to be called doctor – not so some patient may ask him for a prescription, but so that the invidious "mister" may not single him out as an inferior in the group of health practitioners.

There is an ancient maxim about learning to crawl before one walks, and it is the contention of this brief polemic that this is most applicable in the present state of education for hospital administration. With the desire to raise standards, one cannot cavil; with the wish to attain academic respectability, one must sympathize. A sound and secure foundation must be erected, however, before that upper structure from which one may obtain the broader and deeper view can be built.

It may well be regarded as gratuitous to question the validity of current offerings for master's degrees in the field from the standpoint of many tenets of educational philosophy, particularly when they have been established at a substantial cost in time, effort and contributions of volunteer workers, and when they are regarded in many quarters as quite successful. This latter should not prevent valid questioning, however, provided its long run purpose is to assist these programs in improving content and method by keeping pace with trends in professional education which seek to bring about these improvements.

I am emboldened to do this by a comment in a recent survey of possibilities for higher education in our field which reads, ". . . it being a premise of this paper that there is a deficit at this level [master's degree programs] which should be corrected for the sake of better administration and to provide a sufficient base for more advanced education."[1]

The deficit to which that article refers is real and, in my opinion, serious. It requires the earnest attention and thoughtful consideration of every hospital administrator who wishes that the standards of educational preparation in his field may be comparable to those in other professional activities. Furthermore, it is virtually an obligation of any professional worker to be directly concerned in the raising of such standards.

It will be useful at this point to make sure of the meanings of the terms with which we characterize our educational programs. The adjective most in use is "graduate"; and, in my opinion, it is a very misleading one. As long as this term is used, there is certain to be some confusion as to the general nature and purposes of the programs, if not among the enrollees, then among the academicians, alongside whom our scholars wish to stand.

We are not dealing primarily, or even secondarily, with an education whose purpose is to expand the frontiers of knowledge, or to prepare teachers in particular disciplines, although these may be goals of great importance to teaching and research in hospital administration.

Our present educational goal is to develop practitioners – the same kind of goal that medical and law schools have. We, therefore, wish to give a professional education. We have determined that this professional education is best given after an undergraduate preparation (although this is not necessarily a characteristic of all professional education – witness engineering). We are, therefore, providing postgraduate professional education. This may not seem, at first reading, to be an important distinction, but it is hoped that what follows will establish its paramountcy in any examination of the educational problems with which we are faced.

The first question to be explored, as we look at these problems of education, is whether there exists "a sys-

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"At best, hospital administration is a synthesis, drawing on a variety of fields and disciplines"

tematic body of knowledge of substantial intellectual content,"[3] which is a primary need for a professional education.

Hospital administration has actually been described as a "discrete academic discipline" by certain people in the field, although not to my knowledge by any academician from any of the established disciplines. This description seems questionable, since the term "discipline" certainly implies sets of principles — usually built up on a basis of tested hypotheses, methodologies involving systems of analysis, and a considerable body of substantive knowledge. Where these do exist in the field of hospital administration, they do not appear in most instances to be peculiar to that field.

It is interesting to note at this point that the sources used in teaching hospital administration are principally either historical or descriptive. There are no textbooks as such, but only detailed descriptions of hospital operations with some opinions as to alternative procedures. In the periodicals devoted to hospitals, one finds a profusion of articles on how to do it — or "how I did it."

There is nothing intellectually or morally wrong with communication which endeavors to record useful experiences — but unless there is some basis for analysis of these experiences, they do not contribute to the systematization of knowledge. They furnish templates to apply — but if the situation does not fit the template, there is available no understanding of the process, or processes, by which it may be altered to achieve satisfactory results.

The accumulated experiences and knowledge of practitioners may be a fertile source of materials, but very few of them have the opportunity to conceptualize this material, if in fact they possess the particular skills to achieve this transition. This area of activity belongs primarily to the research worker, who will make use of the insights of practitioners as an element in his analysis.

Perhaps the best source of generalization in our field is in the dissertations of those doctoral candidates from various disciplines who have used the general area of the hospital as the field for their formal work. Such examples come to mind as Edith Lentz's "The American Voluntary Hospital as an Example of Institutional Change"; Paul Gordon's "The Top Management Triangle in Voluntary Hospitals"; Albert Wessen's "The Social Structure of a Modern Hospital," and Harvey Smith's "The Sociological Study of Hospitals." While much of the material may be too technical for the student in hospital administration, there is a great deal for the teacher. Unfortunately, such dissertations rarely get published, and their circulation is limited.

This review of the literature, whether it be in descriptive books, periodicals or Ph.D. productions, does not provide evidence for the existence of a "discrete discipline." What it does reveal is that the effective hospital administrator must draw his knowledge from many fields. Most of this knowledge is utilized by any successful administrator in most areas of human activity. This universality was recently explored by Ray Brown in his article, "What's Behind the Administrative Process."[4] He states, "The different fields of administration are ultimately different only in the sense that the enterprises represented in the field may offer different services, or may serve different customers or clients, or may have different production processes or technics, or may have such other topical differences as may be used as a group designation. Actually, they are not different fields of administration, but rather different fields in which administration is utilized."

What may we reasonably conclude? Certainly that there is no separate body of knowledge peculiar to hospital administration. At best, it is a synthesis, drawing upon a variety of fields and disciplines. It may be considered systematic, but only in the sense of application. This, of course, has direct bearing upon the content of master's degree programs, not to mention doctoral offerings.

What the synthesis — perhaps aggregation is a better term — may contain is the next question. The following is suggested as a rough classification.

Three general kinds of knowledge in the field of hospital administration may be discerned — environmental, that having to do with the activities of the hospital, and that concerned with control.

There can be little question about the first category. Certainly the administrative personnel of any organization, whether it be profit or nonprofit, service or product producing, should know as much as possible about the political, social and economic environments in which they are operating. The environments are going inevitably to shape and to limit any major decisions which may be made. The more the individual knows about them, the better qualified he will be to direct the operations of the institution or organization with which he is associated.

Conversely, the less he knows about them, the less likely he will be to produce the leadership which every organization needs. For example, questions of hospital cost are today of great concern to all in our field. The resolutions of these questions will depend largely upon such considerations as the availability of resources, the competition for their use, the choices which consumers may be able to make. These are not questions of equity, or taste. Furthermore, they are not questions which may be understood with reference to a single institution; neither are they problems which are unique to our field. They are essentially economic questions.

The activities area presents peculiar difficulties in view of the number and kind of functions which are car-

ried out in the modern hospital. Hospital personnel are familiar with their variety, and they need no listing here. Course time obviously does not permit a thorough study of each, nor is there any point in developing a jack-of-all-trades. This is the area of "intellectual capacity" described by Chester I. Barnard in "The Nature of Leadership."[4] It is only one of the qualities he describes, but perhaps a more important one in the hospital field than in the steel industry, because of the highly complex operation administered.

Consequently, there must be a choice of areas if the course of study of each function is to be sufficient in time and depth to furnish the prospective executive with the kind of understanding and insight he will need. The basis for choice does not appear too difficult if we first distinguish what are clearly professional activities, and what are trades or agglomerations of technics. We may safely leave an appreciation of the latter to inservice training, on-the-job demonstration and study, and short-term institutes.

The second step, as used by the author, is to consider those professions which account for the major activities of the hospital — and it appears that medicine, nursing and dietetics will be major items in the group.

This, however, is by far the simplest part of the exercise. The choice having been made, precisely what are our students to study? A frequent solution, in the field of medicine, has been to give short, short courses in anatomy and physiology with a liberal sprinkling of medical terminology. This seems based upon the supposition that a knowledge that the word "cholecystectomy" means the surgical removal of the gall bladder will equip the administrator to work effectively with the surgeon.

There is nothing wrong with acquiring this tiny item of knowledge, but even multiplied by the thousands, it is less than a bird's-eye view of the profession.

Is not the object of knowledge in the field of medicine, for the hospital administrator, to understand the objectives of the practice of medicine; to know something about the predominant types of persons who enter the profession, and the kind of education they receive? Should it not include an understanding of the physician's goals, his expectations, both for himself and his patient?

It will obviously be useful to explore the physician's expectations concerning those institutions with which he is associated — and this should include the American Medical Association as well as the hospital. It will help substantially to have some insight into the role of the physician in our society, and how he may respond to the trends in social organization which affect professional groups like his own.

Control presents us again with a multiplicity of choices. Accounting is preeminent among them — as it may be in almost any field. I am very much inclined to agree with Mr. Barnard's contention that every educated person today should have a firm understanding of accounting.[5] The hospital administrator will need much more than a firm understanding — he must be familiar with accounting principles as well as their application, and he must have facility in the use of their products.

Statistics furnish a second means of control — and one which is notoriously slighted or mishandled in most professional schools of any kind. Instruction is apt to brush over lightly descriptive statistics, with the student constructing a few bar graphs and time series. The area of analytic statistics is even less emphasized, so that the student ends up being able neither to produce statistics nor to use them.

That he should be able to use them, that he should be able to reason statistically, is certainly important. To quote Dean M. W. Lee of the University of North Carolina, "The reduction of uncertainty is an essential part of the process of improving the quality of executive decisions. And statistics is primarily a set of methods for reducing uncertainty."[6] Whatever statistics are taught, it must not be an isolated instruction to be surmounted as one more barrier to the acquisition of a degree — nor as a mental gymnastic to keep the muscles in tone. The other courses in the curriculum should make use of quantitative analysis wherever possible so that this tool becomes one which the student may use with skill.

To statistics and accounting may be added personnel management and allied subjects. There will undoubtedly be some objection to placing personnel management in the control classification, since the word has unpleasant connotations when used in connection with human beings. What is meant here, however, is coordination, rather than manipulation or exploitation.

It is very important that instruction in these three categories of knowledge which have been discussed not be limited to description. There should be an approach which permits an analysis and criticism, so that the student is encouraged to develop the kind of knowledge which will furnish him with a sound basis for an understanding of the administrative process in the hospital. The behavioral sciences may well furnish these approaches. For example, a study of the community environment of the hospital may be most meaningful and enlightening if presented from the point of view of the sociologist on the basis of the many analyses of community organization behavior which have been produced in recent years.

Where would one find courses in hospital administration in this compilation? Practically nowhere! It should be borne in mind that basic to the whole discussion is my agreement with Mr. Brown's contention that "this is a field in which adminis-

The courses must distinguish what are clearly professional activities, and what are trades or "agglomerations" of technics

Supplying a unifying theme, interpreting field work and observations, and handling casework are tasks within the province of "practitioners" in hospital administration

tration is utilized." What is needed is the application of this knowledge, these skills and technics to the hospital — and this is best learned in service, on the job. It may be done through field work, through observation, and through residencies — all of which may be integral with course work and which may supply a unifying theme. Such experiences may be accompanied by or preceded by the use of case problems in the field; there are now three casebooks available,[7] and more undoubtedly will be coming.

If it may be assumed that the statements made about curriculum have validity, obviously the next question, and perhaps from many points of view, more important than the preceding ones, is:

Who is going to teach this curriculum — where are we going to find the teachers in, or of, hospital administration? (It may be thought at this point that the author believes there is no need for such teachers; if so, it is hoped that what follows will change this impression.) As Messrs. Bugbee and Pattullo stated in one of the reports of the Hospital Advisory Committee of the W. K. Kellogg Foundation,[8] in the section on education for hospital administration: "The most pressing and fundamental problem is the lack of scholars in hospital administration, or the dearth of well trained personnel for research, education and planning."

Teaching, naturally, must have some reference to curriculum, and the elements in the curriculum outlined will come generally within the disciplines or fields of faculty members already on the rosters of most universities. Furthermore, the courses suggested by the curriculum components will, in many cases, already be listed. These will serve admirably, often with no alteration in content or approach whatsoever.

In a few cases, the necessary course work will not be available. The kind of study advocated for clinical medicine is not, to my knowledge, a part of the offerings of any member of a faculty. It is believed, however, that medical school faculties, apprised of the general goals of the program and the particular goals in the functional areas, will be willing to cooperate in the establishment of the necessary course or courses. The same should be true of the other functions. It is also possible that a two-way thoroughfare may be set up; certainly medical and nursing educators have for some time decried the lack of knowledge on the part of their charges of the administrative requirements in hospitals and allied institutions.

The supplying of this unifying theme, the interpretation of field work and observations, and the handling of casework cannot usually be furnished by existing faculty members. This is the art of this particular branch of administration, and, in my opinion, it falls within the province of the practitioner.

At this point, it will be useful to look at the means by which other professional schools which furnish education in fields of knowledge, both basic and applied, have solved their problems of curriculum and pedagogical resources. Medicine furnishes one method. As we know, basic sciences are taught by individuals whose careers are principally spent in teaching and research — for example, anatomists and physiologists. These men may sometimes be consultants, but they are not usually practitioners, in the sense of the term in which it is being used here. The majority of their time is devoted to the classroom and the university laboratory.

On the other hand, in the development of the students' skills and understandings, they are guided and directed by practitioners. These practitioners may be full-time teachers whose private practice may be principally a support to their teaching, or they may be physicians in private practice who regularly devote some part of their time to teaching. Law schools to a large extent follow a similar pattern.

The teaching of hospital administration may profit from these examples. "Practitioners who teach" will scarcely be considered a unique idea in the field where it has existed in at least one form since the programs were initiated. The form, however, has been enormously unsatisfactory from the standpoint of many students. The student in hospital administration has usually been given his "union card," which may well be his principal objective, but he has been badly shortchanged in the area of intellectual stimulation and growth. The fact that this has been done in a spirit of benevolence and with little or no personal gain on the part of the teacher is a testimony to human kindness, but not to human intelligence.

These shortcomings do not have as much to do with personal wisdoms, understanding and ability as they have to do with a system which bears heavily upon the vocational approach. It is probable that the lower cost of an operation based upon what might be called the "cafeteria" form of education also has its weight.

Almost all hospital administration students are familiar with the current practices referred to, but some practicing administrators may not be. Very simply, it consists in designating a course "Principles of Hospital Ad-

ministration" or "Principles of Hospital Operation" or "Hospital Management." (To determine just what these "principles" are would take quite a bit of pedagogical research in the course materials themselves!)

The program director or one of his associates (program directors, having to eat like the rest of their fellowmen, and clothe and educate their children, will be spending a large part of their time directing a hospital, doing consulting work, or filling lecture engagements somewhere else) will serve principally to arrange field trips and to introduce the 30 to 58 lecturers who will "teach" during the academic year. (The figure of 58 is by actual count.)

These lecturers will rarely be professional teachers. Usually they will be hospital administrators, nurses, dietitians, medical record librarians, accountants, and other specialists who will take considerable time and effort to describe how they perform their particular specialties. There will be very little principle — although there will be many rules — but there will be a large amount of factual material. This factual material is perhaps better presented in MacEachern, McGibony, or Sloan;[9] the student, in using these latter references, doesn't have to worry so much about notetaking.

There are, of course, some earnest justifications for this type of operation. The following is selected from the catalog of a program in an allied field, in order that no particular program in our field may be singled out, but it has a familiar ring: "At the same time, it has been the policy to have a wide variety of professional points of view represented in order to avoid a stereotyped approach to a dynamic field of study." Just what this means is a little difficult to understand.

What essentially is wrong here is the misconception of the roles of student and teacher. A parade of facts or opinions by a practitioner, with a captive audience whose principal activity is note-taking and asking a few polite questions, may be part of the learning process, but it is certainly a minor part. It may also be very costly from the standpoint of the time devoted to it, both by the speaker and by the student. Time is so precious a commodity, particularly for the student in a professional school, that anything about which they can read with understanding, or which they can learn better on a job, should not be part of the curriculum.

The aspect of the student-teacher relationship with which most educators would agree is the reaction between two minds. It is the stimulation which the presentation of understandings and insights developed by a mature intelligence will give to the inquiring and curious mind. The good teacher will frustrate, he will irritate, he will challenge the student, but all the time he will be stimulating him to think, to analyze, to conclude for himself.

This requires a continuous and intellectually intimate relationship; each must know something about the other's processes of thought and approaches to problem situations. It is one of the inevitable defects of modern educational systems that they no longer permit this, except in rare cases. In hospital administration programs, however, classes are generally small, and it is possible to develop the kind of relationship described here even in nine months, with a few instructors.

An example of the kind of experience which has been described can be drawn from the memory of almost every person who has spent some time in a formal educational system. He will remember certain teachers, long after the subjects they taught have receded far into his subconscious, or have become such an intimate part of his intellectual equipment that he could not identify them as discrete elements.

This is not to state by any means that factual, substantive knowledge is not necessary. It is the flesh on the bones — but the bones must be there. A description of the activities of a medical records librarian is only a job description unless it be used as part of the development of such ideas as the quantitative analysis of medical practice. A careful examination of the differing points of view represented by the Professional Activities Studies and the proponents of the medical audit is much more to the point.

The use of the professional teacher who is employed full time by the university raises additional problems. In the first place, the margin between professional salaries and practitioner salaries becomes constantly greater, and, in our culture, this may constitute a substantial barrier. Another factor is that such a person must have had ample experience before he begins to demonstrate his art in a classroom.

Furthermore, the ample experiences must be frequently refreshed by a return to the field, if the art is to be kept vigorous and effective. The practice of a profession does change through the years, and sometimes the change may be very rapid and radical. This is especially true in an operation that coordinates activities of many professions whose development is as dynamic as those concerned with medical care.

Some possibilities occur: vacation relief for administrators; leaves of absence to occupy operating positions where the volume of work for an administrator is temporarily increased, as in the case of new construction; extended tours of observation in suitable hospitals. None of these seems very practical.

Where then are we going to get the kind of teacher-practitioner who ornaments the medical school? What hospital administrator has the time, provided he has the interest and ability, to develop course material which will be reasonably compatible with the general course of study in the program he is serving?

It is surely necessary that the pro-

Teaching is time consuming, and the teacher who runs a hospital must have the time

spective teacher be familiar with the other parts of the curriculum which his students are pursuing. Compatibility is not the only criterion. The practitioner is going to teach the art; therefore, he should know something about the skills and understandings which the students will apply in developing the groundwork for their art. Furthermore, duplication and overlapping must be avoided, considering the small amount of time available. The question of pedagogical methods needs to be considered. Born teachers are probably rare among administrators in any field.

The time necessary even for the presentation and discussion of the prepared material is a substantial obstacle. Last year, in a preceptors' conference, the question was repeatedly asked, "May I assign a resident to one of my staff?" Even the small amount of time usually allotted to residents is frequently found to be a burden by administrators who are interested in education. A much greater amount of time is necessary to do a proper teaching job. Lectures must be prepared and kept current, a substantial amount of reading scheduled for the instructor, examination questions prepared, and papers read. These are not tasks that one can do over a week end or late at night.

Does this mean that the use of the teaching practitioner is impossible in hospital administration? Not at all, but the foregoing, if valid, indicates certain criteria, most of which will have to be met. They are elementary, but they are often overlooked.

In the first place, regularly scheduled time must be available. This means that the teacher-administrator must arrive at an understanding with his board of trustees that he will take up this important assignment, and that it will consume time. The board must agree that such participation is as important as any part of his job. It may mean less opportunity to attend conferences or work in professional organizations, but surely it is at least as worth while. Some boards will understand that the activity of teaching will help the administrator to become more proficient in his job, and perhaps a few will come to regard it as an honor to the hospital.

As a corollary, the administrator must have an organization which will permit him to be absent for classes, as well as faculty meetings, library work, and the other activities which go with teaching. It is probable that for every hour in class he will have to spend initially eight to ten hours; it is doubtful that it will ever be less than three to four.

Another consideration is payment for services rendered. Given the slender resources of the programs, it is unlikely today that any could afford much, if anything, in the way of compensation. This is a situation which must be remedied. Voluntary activity is important in any area of hospital administration; no adequate remuneration can be given to the capable teacher; the prestige of teaching is compensation in itself. The monetary relationship, nevertheless, has certain important aspects: The program is better able to command the best available talent, and so is the university in which it lodges. The program may then reasonably demand attendance at scheduled class sessions and at meetings. The instructor will find that he is truly a part of the program, and will be much more likely to participate in the policy making and decision making which are as necessary in an academic activity as in any other.

The question of status in the university community cannot be overlooked in this examination. The appointment, at whatever rank it is, must come through the regular university mechanism, and the incumbent must have all the privileges of his academic rank.

There is no question that these criteria will be considered impossible by many people in the field; there will be many comments that programs could not exist if they had to subscribe to the majority of them. I contend, however, that they must follow most of them, and the profession must insist that they do. It would be difficult to find an educator who would disagree with Talcott Parsons when he wrote, "Indeed, under modern conditions, a group can hardly be afforded full professional status, unless an important part of it, which is highly respected by the rest, can become specialized in the teaching and advancement of the professional tradition as an intellectual discipline."[2]

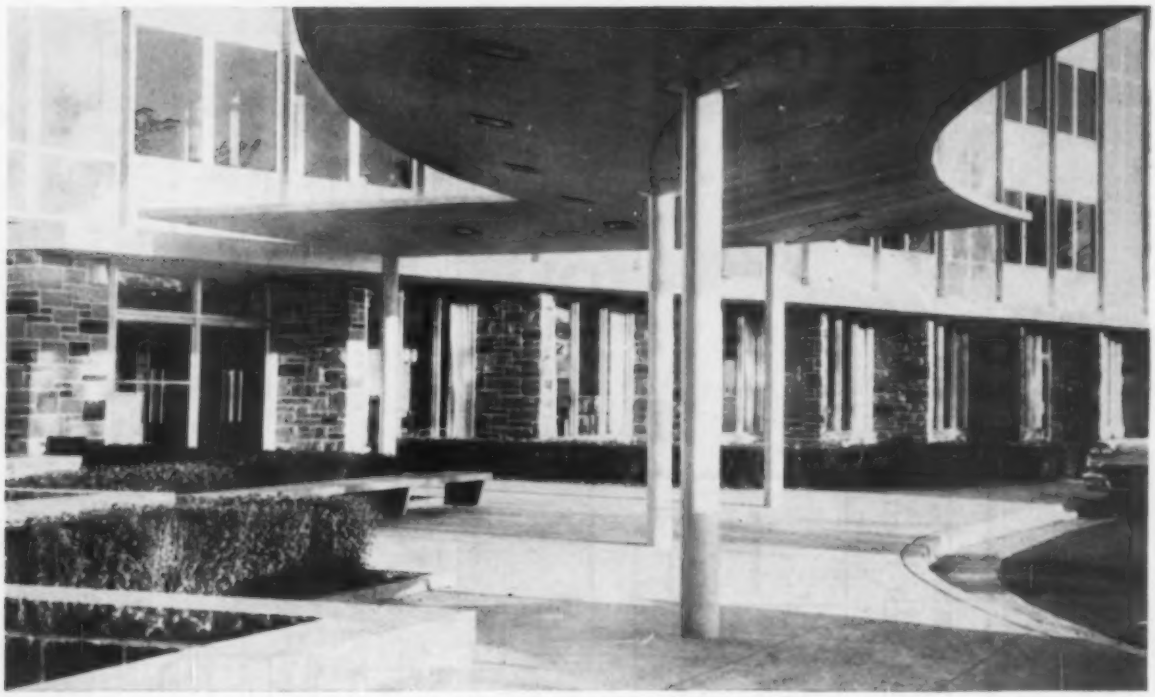
It is almost impossible to develop teachers in any other way. One only has to look at the roster today to realize this. How many of the course directors and associate or assistant directors draw the major part of their earned income from their teaching activity? How many of the instructors want to follow careers in teaching (often they are between jobs as practitioners)? What is the average tenure of instructors, apart from course directors? The answers to these questions indicate what the results thus far have been in any process to develop teachers.

It would be fine if foundations could be found to subsidize teachers, as they were found to initiate programs; this, however, is rarely a foundation activity on a long-term basis. The professional associations should offer a possibility; the cost of an institute or two might carry an instructor for some time, but this is not generally within their scope.

Another possibility is a reduction in the number of programs in order that the student bodies may be larger, and so make a substantial contribution to the direct costs of teaching. Neither private nor state universities will properly support a program for a handful of students for education in a field which the community is barely beginning to recognize. Laws of economics are not suspended in the world of higher education. Some programs may close, but the evidence thus far indicates that others are ready and waiting to enter the field.

We seem to be traveling in a cir-

(*Continued on Page* 156)



A concrete port-cochere supported on pillars leads patients and visitors into the main entrance of West Allis Memorial Hospital. Exterior walls in this section are faced with split-faced granite. Panels are porcelain enamel.

Administrator votes for double corridor plan because it is simple and direct and —

Employes Don't Lose Time Getting Lost

THE simple double corridor plan of the 250 bed West Allis Memorial Hospital, West Allis, Wis., offers a great advantage in preserving expensive man-hours, according to William E. Claypool, administrator of the glistening seven-story hospital opened last spring.

"One of the biggest problems confronting hospitals," Mr. Claypool explained, "is the recruiting, employing and training of personnel. Because of the hospital's simple form, there will be few man-hours lost by disoriented employes. Travel to supporting areas can be accomplished easily."

The hospital's present capacity can, and will, be expanded to 400 beds by finishing the two top floors, which were included in the initial construction to take advantage of lower building costs. Allowance was also made by the architects, Darby, Bogner and Associates of West Allis, for future adjunct facilities, such as a geriatrics building, nurses' residence, municipal health center, and orthopedic school.

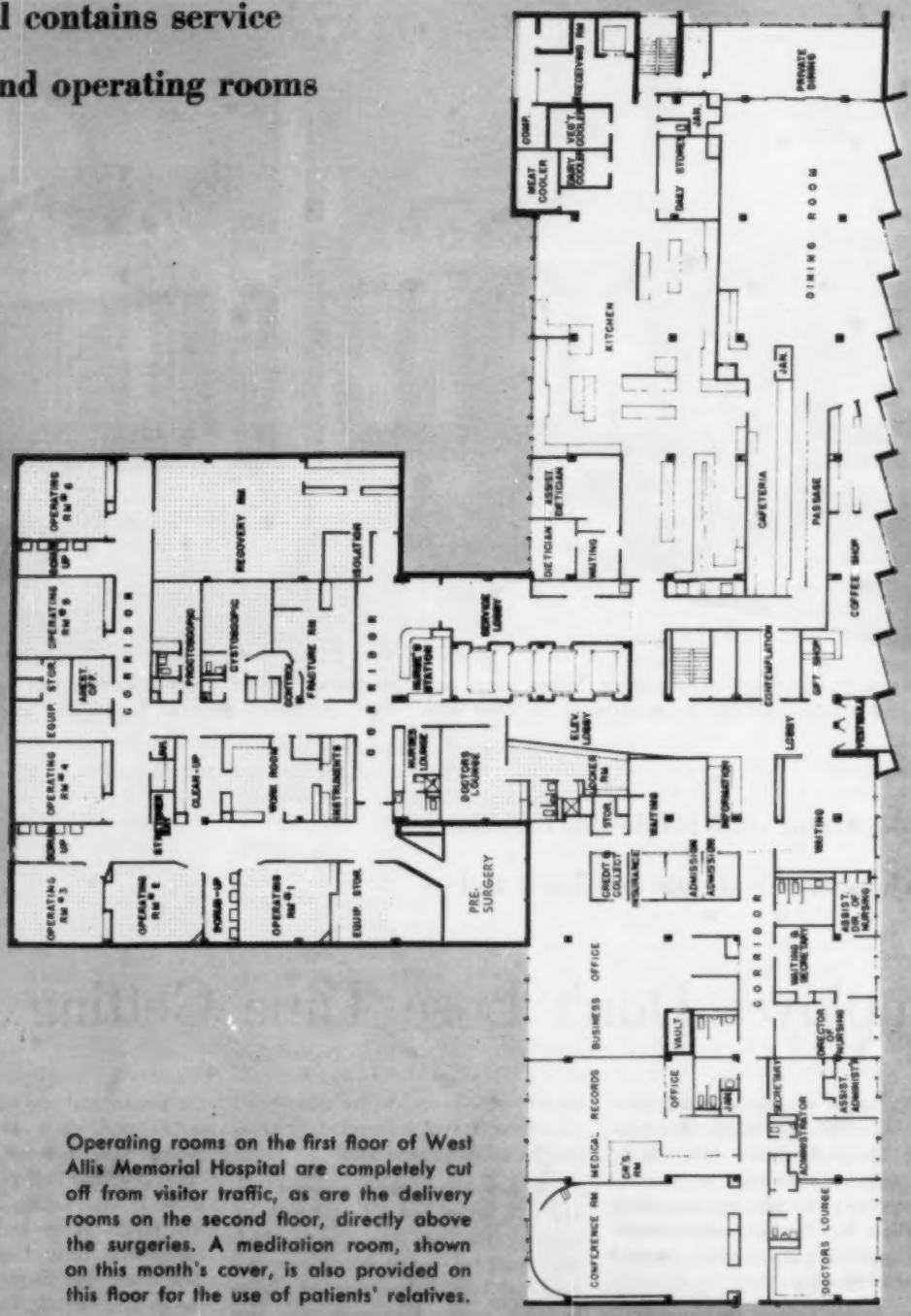
Trunk of the T-shaped hospital is a squat two-story structure housing the mechanical and pharmacy departments and dock facilities on the ground floor, operating rooms on the first floor, and delivery rooms on the second. The entire third floor plus half of the fourth and fifth floors are for general medical and surgical care. The other half of the fourth floor is for pediatrics, and the other half of the fifth floor is for psychiatric care.

The central core area contains elevators, nurses' stations, conveyors linking each floor to the kitchen and pharmacy, treatment and examination rooms, and a central control station

(*See Plans on Next Two Pages*)
(*Text Continued on Page* 96)

The hospital was designed by Darby, Bogner and Associates, West Allis (Milwaukee), Wis. Hospital consultants were Norby-Hatfield and Associates, Milwaukee. William E. Claypool is administrator.

Two-story trunk of T-shaped hospital contains service areas and operating rooms



Operating rooms on the first floor of West Allis Memorial Hospital are completely cut off from visitor traffic, as are the delivery rooms on the second floor, directly above the surgeries. A meditation room, shown on this month's cover, is also provided on this floor for the use of patients' relatives.

The same general plan is followed on all patient floors. The third floor shown here is assigned to general medical and surgical cases.

OUTLINE OF CONSTRUCTION COSTS

West Allis Memorial Hospital, West Allis, Wis.

Total project cost		$6,640,552.00
No. of beds	250	
(Planned for 130-150 additional)		
Cost per bed		26,562.00
Total square feet	184,620	
(6th and 7th floors unfinished)	46,500	
Square feet per bed	738	
Cost per square foot		28.70
Total cubic feet	2,343,008	
(6th and 7th floors unfinished)	525,430	
Cubic feet per bed	9,372	
Cost per cubic foot		2.22

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and the state agency. A similar award will be made each month.

Emergency area is an example of the flexibility included in design of West Allis Hospital

Above: Pigeonholes below the clock in the doctors' lounge contain pocket radios. When a doctor removes his radio, a light goes on at the central switchboard.

Top: Visitors to West Allis can park close to the main entrance. Bottom: Emergency room is divided into separate units so patients have some degree of privacy.

(*Text Continued From Page* 93)

for floor supervision. Certain floors also include informal lounges.

Most patient rooms are semiprivate although provision has been made for a few single rooms and four-bed wards. All patient rooms are air-conditioned with individual thermostats.

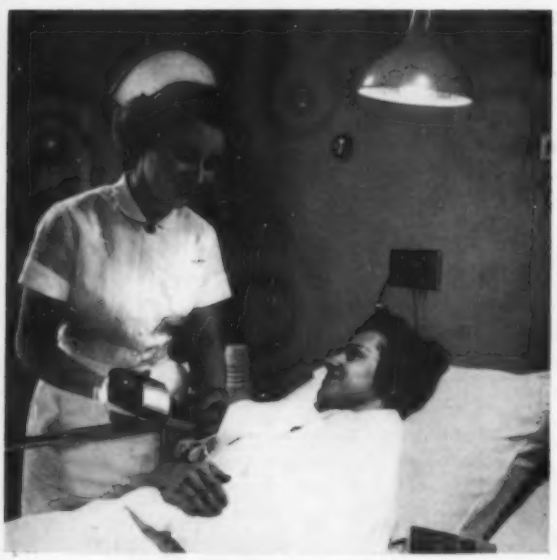
Completely equipped intensive treatment rooms, each containing four beds, are located directly across from the nursing stations on the third and fourth floors. Thus, critically ill patients can be kept under close supervision by the nurses.

An example of the building's flexibility is the arrangement of the emergency room and outpatient area. In the event of a disaster, hospital officials point out, the outpatient department would be an organic continuation of the emergency room, where patients would be given initial treatment. Auxiliary services are readily available in adjacent areas.

The importance of "everyday" outpatient treatment is underlined by the fact that the hospital serves an industrial area with a large potential for industrial accidents, it is explained.

Nobody except the nurse in charge is allowed to enter the nursery, and the area is designed to ensure that this rule is enforced. The doctors' examining room is accessible only from the corridor, and the babies are examined on the counter facing the nursery. The opening to the nursery can be closed by means of sliding doors. Large glass panels separate adjoining nurseries so that the supervising nurse can control the whole department.

An unusual feature of the obstetrical department, hospital authorities



Top: Patient rooms are cheerful and easy to maintain. Bottom: Nurse shows patient how to set controls regulating TV and FM sets.

Above: Engineers check on the heating and cooling system. The water system that supplies the heating and cooling coils in the induction units are divided on each floor of the hospital.

say, is the recovery room. This was included to make the best use of nursing time.

Nerve center for the control of the hospital's mechanical system is the supervisory data control center panel in the engineer's office. Its purpose is to keep the engineer informed of room temperatures, operation and cut-off cycles of equipment, pressures and pertinent liquid levels of hydraulic and pressurized equipment. The engineer can make any necessary adjustments to control temperature and humidity without leaving his office. ■

Above: An unusual feature of West Allis Hospital is that obstetrical patients have their own recovery unit in addition to the usual postoperative recovery room.

This report tells what hospitals may

be getting when they hire graduates of some

Commercial Medical

"The American Medical Technologists will be pleased to assist hospitals, clinics and other employers of qualified Medical Technologists, Certified Technicians, Certified Laboratory Supervisors, Laboratory Directors, and Certified Technologist Specialists in the Biological Sciences. Write or Call."

This broadside covers a lot of territory. In fact, it would appear to be the solution to a hospital laboratory's personnel problems, if the qualifications mean anything.

The American Medical Technologists, a self-constituted registry, was incorporated in New Jersey in 1939 by Curtis A. Bartholomew, J. G. Dacanay, and E. W. Williams. Bartholomew, who runs a private clinical laboratory in Red Bank, N.J., and who is acknowledged by the organization as its founder, has played an active part in its direction through the years. He is now executive supervisor. He got his basic laboratory training on the job in the hospital in Red Bank, where he started washing glassware and worked up to directing the laboratory.

Second in command is E. W. Williams, AMT's paid executive secretary, an organizer who practiced for his present post by working for the American Radiography Technologists, a related organization in that the two groups hold their meetings together, draw members from the same commercial schools of x-ray and medical technology, and have leaders and organizational patterns in common.

The basic organizations of American Medical Technologists are: The Registry of American Medical Technologists, The National Council of Medical Technology Schools, and The Accrediting Commission for Medical Technology Schools. Related to these basic organizations are the American Board of Bio-Analysts and the College of American Board of Bio-Analysts. Finally, there are The College of American Medical Technologists, Master Technologists Guild, and Order of Accomplished Bio-Analytical Scientists. Headquarters for most of these is now Enid, Okla.

Dominating the organizational structure is the American Medical Technologists, which reportedly includes 10,000 registrants of various gradations of experience and training. Dominating the AMT is its executive council, on which Williams, Bartholomew and AMT President Hugh Woosley are active. There are five members of the executive council; two, Williams and Bartholomew, serve automatically and permanently, the one by dint of being executive secretary, and the other as resident agent in New Jersey and judiciary councillor.

As judiciary councillor and chairman of the executive council, Bartholomew is given operational super-

WHICH TECHNOLOGISTS HAVE THE TITLE?

Confusion in the minds of hospital administrators and physicians about the qualifications for certification of medical technologists is leading to the hiring of unqualified laboratory personnel.

MT(ASCP) is the registration insigne of medical technologists who have had three years of college plus a fourth year of clinical training in a hospital school of medical technology headed by a pathologist and approved by the American Medical Association.

Board examinations for this degree are given semiannually by the Registry of Medical Technologists of the American Society of Clinical Pathologists in Muncie, Ind.

M.T. are the initials used after names by a broad cross section of medical laboratory personnel, many of whom had their initial training in commercial or private schools of medical technology; others learned on the job, and still others were trained in the armed forces.

The M.T. is awarded by a self-authorized registry, American Medical Technologists, functioning out of Enid, Okla., on the basis of examinations often proctored in AMT members' homes.

Technology Schools

vision of the executive secretary, and the two of them are members of all committees, departments, agencies, boards and councils of the Registry, according to its by-laws. Bartholomew also has many other titles (this past year he was chairman of the auditing committee that examined the books), but none so important as executive chairman, which gives him the authority to run AMT between meetings of the executive council.

Prominent on the executive board of AMT are representatives of private medical technology schools. Woosley, reelected this year as president, is dean of Elkhart University in Indiana, and Vice President Chester Dziekonski is an official of Carnegie College in Cleveland. Another member, William F. Young, is director of Southern Academy of Clinical Technology in Nashville.

AMT leadership has organized a systematic ladder of "certifications," "registrations," "fellows of college," "specialists," and "diplomates of boards." Aspiring to these ratings can keep an energetic member busy for a lifetime. Each rating has examinations, and there are many exceptions or alternative routes to the coveted "degrees." All have application fees, and there are annual renewals.

At the bottom of the ladder is the Certified Technician (C.T.), which requires no formal education but can be obtained by passing a *written* examination in eight laboratory tests.

Higher up the ladder is the certified medical technologist (M.T.), who can get this title after two years' laboratory experience, or upon graduation from an accredited commercial school of medical technology. Examinations are often proctored by other M.T.'s meeting in members' homes. The *AMT Journal* recently announced such a session at the home of George Zuccala in Hartford, Conn. It costs $15 a year to be an M.T.

The next step up the ladder is the Medical Scientist rating, which is described as being equivalent to a master's degree and can be earned by the accumulation of 160 AMT credits. Ninety credits are automatically accorded all certified M.T.'s, and the rest may be accumulated five or 10 at a time for attendance at regional and national meetings. A declaration of intent to work for this certification must be filed in the AMT office, together with $10 a year to maintain the file. Executive Secretary Williams says of this program, "Ultimately every Certified Technician coming into the registry can continue his education until he becomes qualified for an M.T. rating and then continue on until he can establish his Scientist Grade rating."

A few years ago, AMT set up a Biological Sciences Board for "specialist certification." Stated prerequisites were college plus experience, or just ten years' experience, and until 1960 a certified M.T. having these qualifications could get in for $15 without examination. For the same fee plus an additional $5 yearly there is a certificate for medical technology instructors. There is also one for clinical laboratory supervisors, and another for laboratory directors.

Quite apart from these gradations and specialist ratings, M.T.'s have an array of titles and certifications open to them. They can be elected Associate of the American College of Medical Technology (AACMT). Or they can become Fellows of the American College of Medical Technology and use the initials FACMT after their names, and as such are eligible for tapping by the Master Technologists Guild, a secret order.

Still another offshoot of AMT is the American Board of Bio-Analysts, or the "hyphenated analysts" as they are nicknamed to avoid confusion with another group, the American Association of Bioanalysts, with which they have no connection. ABB-A was incorporated in Trenton, N.J., in August 1959 to give college graduate level examinations in 13 biological fields for certification as specialists or Diplomates of the Board (DABB-A). For the first year candidates only had to have sufficient education and experience, and a $50 certification fee. By March 1960 there were 79 DABB-A's, including an Indianapolis newspaperman who just wanted to see if he could buy a degree.

Officers of ABB-A have included Bartholomew, Williams, Woosley and Clayton J. Ettinger, who heads Great Lakes College in Detroit, where many AMT leaders, including Williams and Woosley, got their Sc.D. degrees. Great Lakes College is not listed as an accredited institution by the U.S. Office of Education.

There are some AMT awards for which the membership does not have to pay — Medical Technician of the Year, Distinguished Service Award, Exceptional Meritorious Award and,

highest of all, the Order of the Golden Microscope. Board members have been the principal recipients of this award; this year it was given to President Woosley.

On occasion, leaders of AMT have conferred degrees and honorary awards on doctors and scientists of distinction. For example, at the last

Newspaper Writer Describes Cleveland School

Housed in a two-story building wedged between a grocery store and a restaurant on Euclid Avenue in Cleveland, Carnegie College trains medical technologists, x-ray technologists, medical assistants, medical secretaries and combinations of the four.

It is not recognized by the American Medical Association, the Ohio Hospital Association, the Cleveland Hospital Council or the American Society of Clinical Pathologists.

It does, however, have a definite relationship with the American Medical Technologists, being one of the early schools accredited by AMT's Council on Education, Qualification and Standards, and more recently by the AMT-affiliated Accrediting Commission for Medical Technology Schools.

The president of Carnegie College, Elmer L. Koenemann, is also president and owner of Carnegie Institute in Boston, Carnegie Institute in Detroit, Eastern School for Physicians' Aides in New York City, and California Institute of Medical Assistants in Los Angeles. He says Carnegie in Cleveland, which began training medical technicians in 1949 and has graduated hundreds since then, is "the largest, fastest-growing and most progressive school of its kind in the U. S."

A good measure for a school – progressive or otherwise – is its faculty. Among the instructors at Carnegie, less than half claim college degrees. Even department heads do not seem to be required to have such training. The Carnegie College preview supplement lists heads of such critical departments as clinical chemistry, hematology, and x-ray without college degrees.

There is no lack of other degrees, however. President Koenemann sometimes writes DABB-A after his name. So do several members of his faculty.

DABB-A means Diplomate of the American Board of Bio-Analysts.

This title was also conferred upon Dan Berger, *Indianapolis Times* reporter, upon payment of $75 last December. Like everything else, degrees are going up in price. According to *Clinical Chemist*, a little earlier a DABB-A was offered to a nonexistent chemist for $50 after a fake name and faked credentials were presented to the headquarters of the American Board of Bio-Analysts. No transcripts, records or recommendations were requested.

President Koenemann holds numerous degrees from this same board, including a "chair in Bio-Analytical Jurisprudence" which has caused some surprise in Cleveland medical circles.

"I don't say the honor doesn't exist," said Dr. Samuel Gerber, the county coroner. "I do say I never heard of it."

Dean of men at Carnegie College, and vice president of the American Medical Technologists, is Chester B. Dziekonski. According to the official journal of the AMT, Dziekonski is also a "diplomate of the American Board of Bio-Analysts" and holds a bachelor of science degree. Yet, on May 17, 1961, when he appeared before the education committee of the Ohio House of Representatives in Columbus, Ohio, he admitted he had never finished college.

The administrative dean of Carnegie College is Charles Feistkorn. According to a *Cleveland Press* story, he said he was working on a Ph.D. from Avon University, a Carnegie affiliate, in Boston.

Upon investigation, the *Press* discovered that Avon University in Boston is not a university at all, but a college with no authority to grant such degrees. "Dr." Andrew D. Fuller seems to be dean, chancellor and president. The attorney for Avon, who is also a member of the Carnegie faculty, said the degrees granted came from Avon University in Washington State.

Avon University in Washington turns out to be nothing more than an incorporation paper taken out in 1952 by Andrew D. Fuller Sr. and Andrew D. Fuller Jr., a post office box, now closed, and a sum of money in the Puget Sound National Bank in Tacoma, where a cousin of the Fullers is employed.

Another measure of a school is its entrance requirements. Carnegie College says it requires a high school diploma or its equivalent, and when *Cleveland Press* Reporter Carolyn Means applied for admission, she was afraid that the school would discover her false credentials. She needn't have worried. The public relations director of the school who interviewed her for admission did not even ask if she were a high school graduate. When she filled out the application blank, he told her not to bother listing the addresses of her references.

Of the hundreds of students attending Carnegie College last year, only a handful came from Cleveland. Most were recruited by salesmen, called registrars, working the farms and small towns of Ohio, Pennsylvania, New York and Michigan. Salesmen seem to use the hard-sell technic. Parents are told they must make up their minds immediately because the salesmen will not be back, and they must put down $115 toward college expenses. Of this amount, the salesman is allowed to keep $100 – he is strictly on commission – and sends $15 back to Carnegie.

Miss Vincent is a staff reporter for the *Cleveland Press*. This report is based on a series of articles published in the *Cleveland Press* between October 1960 and June 1961.

annual meeting in Cleveland, in June, both Norman Francis Conant and Dr. Jonas E. Salk *in absentia* were awarded the Order of Accomplished Bio-Analytical Scientists and made Diplomates of the American Board of Bio-Analysts (DABB-A), all of which was widely publicized. Since then both these famous scientists have

Beatrice Vincent

Tuition at Carnegie is not low. Students taking the medical technologists course pay $1395 for twelve months, the x-ray technologists course costs $695, and the medical technologist and x-ray course together cost $1790. Salesmen urge students to take the combination. In 1960 there were 590 students enrolled.

If the parents of the prospective student cannot pay cash for the whole tuition, terms can be arranged through the Medical Credit Corporation, a type of loan company owned by Koenemann, owner of Carnegie College.

Koenemann, who says he is a millionaire, says he has 18 sources of income. One is room rent from his own hotel and residences in which out-of-town students are required to live. One of these, Raymour Hall, described in the Carnegie catalog as a "comfortable mansion near the cultural center of Cleveland" and referred to as a fraternity house for men students, was found on investigation to be almost uninhabitable, with broken windows covered with cardboard, and dilapidated furniture. It was destroyed by fire in March 1961.

One of the strongest selling points used by the salesmen is that credits earned at Carnegie can be applied toward a college degree at colleges and universities. When questioned by the *Press*, administrative dean Feistkorn named only one university that recognized Carnegie's credits — Kent State University in Kent, Ohio. This was immediately denied by Kent State University.

On Feb. 11, 1961 a group of parents told the *Press* that President Koenemann assured them he did not know his salesmen were making such claims for Carnegie. But *Preview*, official Carnegie publication, says on page 32, "Some colleges and universities accept Carnegie's credits toward a college degree."

Both students and parents complained to the *Press* that offices at Carnegie College are "bugged," that telephones are fitted with a mechanism that records conversations, and that briefcases containing recording devices are used to pick up conversations. Koenemann told the *Press* that a member of his staff had recorded conversations with representatives of Cleveland hospitals.

When he appeared before a meeting of the education committee of the Ohio House of Representatives in Columbus on May 3, 1961, Koenemann not only used his brief case recorder to preserve testimony but followed witnesses and representatives into the corridors with it after the hearing was over. This caused some consternation among the lawmakers.

Although the school graduated some 225 medical technologists, x-ray technologists, and medical and x-ray technologists in 1960, it is difficult to find many Carnegie graduates at work at the professions for which they were presumably trained.

Some hospitals hire them for routine work and retrain them if they are apt. In one Cleveland hospital, according to the doctor who heads the x-ray department, a Carnegie graduate, who worked as an orderly for several years, was finally retrained and given a job in the x-ray laboratory. In another, a girl graduate working as a nurse's aide was completely retrained and put to work.

In an effort to show how well its graduates are accepted, Carnegie publishes a list of some 750 successful graduates and the places where they are supposed to work. The *Cleveland Press* checked the hospitals where they are said to be employed.

Of the first 100 hospitals to reply, only 20 reported that Carnegie graduates were working at the jobs for which they were trained without additional training. Thirty-seven hospitals said the graduates they hired had either been completely retrained or given additional training.

Forty-three hospitals reported that the graduates did not work there. Some said they had never heard of them. Others said the graduates had worked there only a brief period. Some said they had worked there but had left as far back as 1956.

In the fall of 1960, the *Cleveland Press* ran a series of six stories about Carnegie College. In December of the same year, students complained to the *Press* that they had been summarily removed from the quarters to which they had been assigned and sent to live at Fenway Hall, a commercial and apartment hotel acquired by Koenemann in November.

Then, in February, after months of unrest at Carnegie, a number of students revolted, briefly picketed the school and were suspended. The chief causes of complaint were unpleasant housing at Fenway Hall and Raymour Hall, the poor course of study being offered, inadequate teachers, a lack of study space and the lack of a library.

At Fenway Hall, the promised library consisted of empty bookshelves, and the basement study hall was often locked or rented to outsiders.

As a result of the *Cleveland Press* articles, a bill to regulate the training of medical technologists was introduced in the Ohio State Legislature, but died in committee. However, several state representatives and senators have volunteered to present another bill when the legislature convenes again. ■

Schools charge tuition fees up to $1395; may have as many as 40 students per instructor

asked that their names be removed from DABB-A lists and as recipients of the award.

Both AMT and ABB-A have honors and membership categories to fit almost anyone related to the health field. Scarcely a program passes that some hospital administrator is not asked to be a key speaker. According to a membership survey done last year, AMT had 57 hospital administrator members; no doubt there are more now.

Personnel from public health departments are used extensively for regional and state programs. Not many physicians have been drawn into AMT, although last year's membership survey showed 27 osteopaths and 14 chiropractors. An osteopath, Dr. W. L. Silverman of Philadelphia, represents private medicine on an accrediting commission for the commercial schools.

Since only students of "accredited" schools are eligible to take an examination for registration with AMT immediately on graduation, it is important to ask, "How do schools become 'accredited'?"

The private schools are not accredited by the usual accrediting bodies for academic institutions nor recognized by such professional organizations as the American Hospital Association, the Catholic Hospital Association, the American Medical Association or the American Society of Clinical Pathologists. They have their own accrediting agencies, which are not listed as nationally recognized accrediting agencies by the U.S. Office of Education.

The first of these, an AMT Council on Education, Qualifications and Standards, formed in 1957, had as its key members Hugh Woosley, Elkhart University, and Chester Dziekonski of Carnegie College. Both Elkhart and Carnegie were accredited. So were other members of the American Association of Medical Technology Schools, including Eastern in New York and Franklin in Philadelphia.

By 1959 it was felt that "accrediting" needed a more formal base. A National Council of Medical Technology Schools was formed with I. Zamost, who heads Franklin School of Science and Art in Philadelphia, as president; William Keany of Carnegie Institute in Boston as secretary, and E. L. Koenemann of Carnegie in Cleveland as membership chairman. With the AMT, this group then founded the Accrediting Commission for Medical Technology Schools. Bartholomew and Williams signed the incorporation papers and are AMT's official representatives. I. Zamost and Dr. Stanley Reitman of Gradwohl School of Laboratory Technique in St. Louis are the council's representatives. All 13 members of the National Council of Medical Technology Schools are accredited.

A. Stephan Michaelson, Ph.D., FACMT, DABB-A, owner-director of Precision Analytical and Research Laboratories in Chicago, is the chief inspector of the Accrediting Commission. Michaelson told the *Cleveland Press*, according to a *Press* story of May 31, 1961, that he received a Ph.D. in bio-chemistry from the Stanford University, Palo Alto, Calif., in 1936. The registrar's office at Stanford denied that Michaelson was granted a degree in that or any other year.

Altogether there are 16 accredited private schools of medical technology and another 25 or so that have not achieved this distinction. They are located in major population centers but draw their students largely from rural areas. They are mostly found in big, old, one-family houses, commercial lofts and office buildings, and are owned and directed by a wide assortment of promoters and businessmen, some of whom are lawyers, osteopaths, dental hygienists and optometrists.

Most of these schools offer several courses, the usual combination being medical and x-ray technology, and secretarial training. Others also give courses to dental assistants, physical therapists, and practical nurses, and at least one, Commonwealth College of Sciences in Houston, offered mortuary science and funeral directing. The number of students attending such schools is hard to determine, since there is no way of verifying the claims of each school nor of distinguishing between types of graduates. Franklin School of Science and Arts in Philadelphia, for example, claims more than 5000 graduates "into the medical field" (presumably medical and x-ray technologists and secretaries) in the last 40 years. Northwest Institute of Medical Laboratory Technique, in Minneapolis, claims 6000 of all kinds. Estimates place the number of medical and x-ray technologists turned out each year by all the private schools at between 1500 and 3000.

Tuition per student in accredited schools ranges from a low of between $620 and $720 at Dell School of Medical Technology in North Carolina, Florida College of Medical Technology in Miami, and Southern Academy of Clinical Technology in Nashville to a high of $1395 at Eastern School for Physicians' Aides in New York City. Eastern is one of the many that offer a combination course for medical and x-ray technologists.

Fees go up if students elect to pay by the month. At Eastern and other Carnegie Schools they increase $100, from $1395 to $1495. Financing at Carnegie is by the Medical Credit Corporation, owned by Koenemann, who heads the Carnegie Schools.

Most of the schools publish catalogs and brochures, use newspaper and classified telephone directory advertising, send direct mail to high school graduates, and employ hard-selling salesmen for follow-up home

visits. The salesmen, who are called "registrars," may work on commission. At some schools where the down payment is $115, the salesman gets to keep $100. Parents who are persuaded to sign the school contract without taking time to read and understand it may be liable for 25 per cent of the total tuition — amounting to several hundred dollars — even if the student never goes to the school.

Just how many salesmen are employed is not known, but an ad that ran in *Lab World* in May 1958 appealed to technicians to try their hand at selling: "TECHNICIANS. You can earn $8000 to $12,000 a year as registrar for a private school of medical technology if you are willing to travel and like people. Openings in East and Central states."

How many of the students who enroll withdraw is not known, either. Certainly there are many statements in school catalogs and bulletins which, when investigated, might cause students to change their minds. There is the practice of including "college" or "university" in the names — Commonwealth College of Sciences in Houston, and Elkhart University in Indiana, for example — giving the impression that these are indeed colleges and universities in the generally accepted sense of the word. Most of the brochures make much of their connections with the American Medical Technologists and list as many other approvals as they can muster, ranging from some quite legitimate ones, such as state approval for veterans' training, to others that don't mean very much, like "Recognized in Washington, D.C." and "A Texas Corporation — completely air-conditioned."

The last issue of the *AMT Journal*, in fact, listed the AMT as "registered as a national registry by the Government of the United States." When queried about this, Secretary Williams explained that this had reference to the "name and insignia of our organization being registered in the Copyright Office of the U.S. in Washington, D.C."

Dell School of Medical Technology in North Carolina says it is "licensed by the State Department of Public Instruction" but neglects to add that it is licensed as a trade school, whereas Carnegie in Detroit announced that it is the "only school licensed by the State of Michigan to train Medical Assistants," but did not mention that there are 35 A.M.A.-approved hospital schools of medical

STUDY REPORTS WHAT'S WRONG WITH SCHOOL

A summary of what's wrong with one school of medical technology was prepared in the case of Northwest Institute of Medical Laboratory Technique in Minneapolis not long ago. Following are the points made in an evaluation study which was undertaken by a medical laboratory technic inspection committee appointed by the Minnesota Department of Education:

1. In essence this school is attempting to teach a course in medical technology instead of laboratory technic.
2. Because the students have virtually no background in scientific and medical subjects, the curriculum is much too ambitious for the time spent in this type of training.
3. A majority of the regular instructors are not qualified by either training or experience to teach medical technology.
4. In addition to the poor qualifications of the instructors, the instructor-student ratio is far below accepted standards.
5. The facilities in the judgment of this committee are inadequate to properly train students in acceptable laboratory technic. The inadequacy exists in some instances because of insufficient equipment while in other instances because of outmoded equipment.
6. This training has the distinct disadvantage of offering the student almost no clinical experience with the result that the student has not learned to cope with clinical situations. Training without actual clinical experience is at best second rate and is not acceptable even at laboratory assistant level of training.
7. A nonclinical training center such as this has the difficult if not almost impossible task of attempting to provide students with practice material simulating clinical entities. Because of this limitation, the student is either not exposed at all or only briefly to abnormalities with which it is essential he be familiar.
8. Because of lack of clinical experience, the student has difficulty correlating his factual knowledge with laboratory findings and experience. This was clearly evidenced in interviews with the students by members of the committee.
9. A number of discrepancies were encountered between statements in the brochure and in the questionnaire completed by the school with what was found by this committee through observation and interview with the students.

technology in Michigan, which do not have to be licensed as trade schools because they are fully recognized professional schools.

However, the big emphasis in the school bulletins is on career potential, with descriptions of future job possibilities having high pay and professional status. There are testimonials from past students and future employers. Here are samplings from three accredited schools:

Dell School of Medical Technology (N.C.): "Although the subject matter may sound technical and involved, it is not especially difficult for one who has completed high school . . . Many students are employed before they complete the course."

Northwest Institute of Medical Technology (Minn.): "Training at Northwest will bring you invaluable prestige. You will become a preferred and specialized individual – with professional qualifications and earning potentialities far in excess of the high school or average college graduate."

Manhattan Medical & Dental Assistants' School (N.Y.): "If you long to travel in warmer climates during the winter months and cooler places during the hot, sultry seasons of the year, Manhattan training can give you a permanent passport to hospitals, laboratories and doctors' offices anywhere. . . ."

In general, the catalogs portray school facilities and faculties in such a way as to convince prospects that all is well academically, with photographs of contented, happy students giving the impression that all is also well socially. The extent to which this is true might be measured against the picket lines of students thrown up against Carnegie College in Cleveland last spring to protest unpleasant housing, poor courses and inadequate teachers.

In Minneapolis 29 students at the College of Medical Technology sent a petition to the Better Business Bureau in 1959 charging misrepresentations in the catalog, including exaggeration of the size of the school. The group stated that there were fees beyond the tuition charge, although the catalog said there were not; that vocational advisors listed are actually salesmen; that the faculty and staff roster was inaccurate and certain courses listed were not actually given. The complaint also stated that laboratories were crowded, classrooms were inadequate, certain instructors were incompetent or unqualified; that dormitory facilities were inadequate and overcrowded, and that school record-keeping was inconsistent.

This and other developments led the Minnesota High School Counselors Association to support legislation to regulate the claims made by some of the institutions. "Our biggest problem," said Loren Benson, legislative representative of the association, "is students who come from out of state. Many have never seen the schools before they arrive." The *Minneapolis Star* commented, "Many times the disenchanted students come from rural homes where it has meant a real financial sacrifice to pay for the schooling." Loren Benson added, "Faced with the alternative of telling the folks back home that 'I've been taken,' the student often decides to stick it out. . . ."

Basic entrance requirements for almost all commercial schools are the

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The following commercial or private medical technology schools were listed as accredited in August 1961 by the AMT-sponsored accrediting commission for Medical Technology Schools:

FLORIDA:	Florida College of Medical Technology 2100 West Flagler, Miami
ILLINOIS:	American Academy of Medical Technology 189 West Madison, Chicago
	**Chicago School for Medical Technologists 410 South Michigan Avenue, Chicago
INDIANA:	Elkhart University 324 South Main Street, Elkhart
MASSACHUSETTS:	Carnegie Institute 65 Anderson Street, Boston
MINNESOTA:	*College of Medical Technology 1900 La Salle Avenue, Minneapolis 3
	Northwest Institute of Medical Technology 3408 East Lake Street, Minneapolis
	*Professional Business Institute 1402 West Lake, Minneapolis
MISSOURI:	Gradwohl School of Laboratory Technique 3514 Lucas Avenue, St. Louis
NEW YORK:	Eastern School for Physicians' Aides, Inc. 85 Fifth Avenue, New York
	Manhattan Medical & Dental Assistants' School, Inc. 1780 Broadway, New York 10
NORTH CAROLINA:	Dell School of Medical Technology 66 Haywood Street, Asheville
OHIO:	Carnegie College 4707 Euclid Avenue, Cleveland
PENNSYLVANIA:	Franklin School of Science and Arts 251 South 22nd Street, Philadelphia
TENNESSEE:	Southern Academy of Clinical Technology 2122 West End Avenue, Nashville
TEXAS:	Commonwealth College of Sciences 102 Drew, Houston 6

*Provisional Accreditation

**This is the name given in the Accrediting Commission listing; the school catalog and letterhead use the name Chicago School for Medical Technicians, at the same address.

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same — high school graduation or its equivalent. Not very much is said about high school grades nor, for that matter, high school science. It would appear that almost anybody who wants to be a medical technologist can become one. In fact, in its bulletin the American Academy of Medical Technology in Chicago asks the question, "Who can become a medical technologist?" and answers, "Almost anyone who sincerely desires to serve in this field."

What "the equivalent of a high school education" seems to mean, in some schools at least, is that the student has enough money. In most schools qualifying exams may be substituted for a high school diploma. Of this practice in Minnesota, Rep. George Murk of the state legislature said: "Many of the schools give phony tests, but qualification barriers melt away rapidly as the solicitor establishes the ability of the prospect to make a down payment."

Just recently in New York City, in a documented situation, Eastern School for Physicians' Aides gave such a test, in lieu of a high school diploma, to a 19 year old New Jersey girl who had left school in her sophomore year with a poor academic record (she was passed conditionally into high school and had no science). She passed the test, which took half an hour and was of the multiple choice type. It was graded while she waited, and she was told she had "done very well." She paid her $15 application fee and was given a receipt setting her entrance date as Nov. 13, 1961. This was done without waiting for the official transcript of her grades from her high school.

The directors, deans and others responsible for the training offered by commercial medical technology schools represent many different professional, semiprofessional and pseudo-professional backgrounds. Most of them have one thing in common — lack of professional or academic educational experience *related to pathology or clinical medicine.*

This does not mean they do not have professional or academic training, or degrees. The M.D. who heads Gradwohl in St. Louis is an internist. The medical director of Eastern in New York is a radiologist. Only one has claimed to be a pathologist: Alfred P. V. Auersperg, who was listed in Boston Carnegie literature as "Director of Laboratories and Pathologist," was investigated by Massachusetts pathologists, who found that he had not passed his boards and was not listed with the American Board of Pathology.

Some of the schools' directors seem to have a combination of degrees. Head of Franklin School in Philadelphia, I. Zamost, who is also on the accrediting commission, has been listed as both an M.D. and a Ph.D., and his son, Karlton, an instructor at the school, said he was a D.O. as well. There are M.D.'s listed as members of the staffs in the catalogs of many schools; in actual fact, most of them play a minor educational role, giving some lectures but in the main having little or nothing to do with the teaching of laboratory technic. Others prominent in school programs have academic degrees of one kind or another. Charles R. Wolf, director of the Professional Business Institute in Minneapolis, has as impressive an assortment as any: B.S., R.T., M.T., O.D., Sc.D., FACMT, FICOS and FAOO. Actually, Wolf is an optometrist.

For the most part, the actual task of instructing students in the technics of medical laboratory work is left to personnel without college degrees who have learned their laboratory technics in commercial schools of medical technology, in the armed forces, or in private laboratories or hospitals. Often these are certified by the American Medical Technologists.

Take Northwest Institute of Medical Laboratory Technique in Minneapolis, for example, a fully "accredited" institution that usually maintains an enrollment of around 250 medical technology students. Last available catalog showed Dr. J. Short to be the medical director, though the caption beneath his name noted that he was deceased. Two living doctors, his son, Marshall Short, and Herbert Jones Jr., were also listed and would appear to give some lectures. However, even more recent information on the faculty indicates that the 250 students are taught mainly by the following:

James T. Rehder lists a B.A., an M.S., and a Ph.D. from Metropolitan University, an inactive degree mill in Los Angeles. He took his clinical laboratory training at Northwest Institute and teaches chemistry.

Robert Gleason has no academic degree. He took his laboratory training in Navy laboratory school and teaches bacteriology.

Harvey Radman, no academic degree, extension courses at University of Minnesota, teaches parasitology and tissues.

Harold L. Rolf, no academic degree, laboratory training, Northwest Institute, teaches x-ray and physical therapy.

Margaret Plude, no academic degree, laboratory training, Northwest Institute, teaches urinalysis.

Leonard L. Munson, no academic degree.

Chapter II, Section 5 of the Basic Document for the Accrediting Commission for Medical Technology Schools, which goes into effect January 1962, states that in practical laboratory procedure, the student-instructor ratio shall not exceed 30 to 1. At present the ratio is higher in

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Indications: As an adjunct to effect hemostasis in bleeding associated with capillary oozing. ***Use:*** Strips—temporary packing of bleeding cavities, nasal passages, and tooth sockets; pads—temporary packing of surgical beds as after biopsies and to cover more or less extensive areas as in laparotomies; pledgets—in neurosurgery and in dental work for small localized bleeding areas; Foley cones—in prostatectomy.

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some schools and classes, lower in others. Elkhart in Indiana reports 40 to 1; the Professional Business Institute in Minneapolis, 30 to 1.

The important question is, "How many students *should* be taught at the same time?" Basic requirements of the Council on Medical Education and Hospitals of the American Medical Association allow only two students to every member of the teaching staff, since much of what is taught is generally of a tutorial nature.

How much time do students in private schools spend in courses and what do they study? The basic document for their Accrediting Commission says that a medical technology course of 1500 clock hours is sufficient. Accredited school catalogs show a wide variation in how this is spent. For physiology and anatomy, Northwest lists 12 hours and Eastern 80; for tissue technic, Northwest 30 hours and Eastern 162; for hematology, Northwest 150, Eastern 195.

Some catalogs go into great detail in describing course content. Eastern's, for example, describes hematology (including blood banking) as follows: "Physiology and formation of blood; Hb. determination, erythrocyte count, leucocyte count, differential count, reticulocyte count, direct and indirect platelet count methods. Discussion of the blood diseases: Leukemia, the anemias, polycythemia, hemophilia, etc. Study of prepared slides of the various blood diseases. Erythrocyte sedimentation rate: Cutler, Westerngren and micro methods. Prothrombin time. Red cell fragility. Character of the clot, clot retraction. Theory of blood groups; blood grouping, M and N factors. Cross matching. Theory of Rh factor and sub-types; Rh typing. Tests for anti-Rh agglutinins and blocking antibodies. The Rh factor. The L. E. cell phenomenon." One hundred and ninety-five hours would be insufficient time for a good student with a solid background in college biology to learn all this, according to pathologists who teach in approved hospital schools. In fact, A.M.A.-approved schools of medical technology allow a minimum of three months for this subject.

The lack of a wide variety of pathological specimens on which to develop judgments is another problem of the commercial schools. Since few if any of them have formal hospital connections, specimens are hard to obtain, except indirectly through instructors who are also working in hospitals and bring specimens away with them, or by the more direct route of commercial clinical laboratories.

All accredited commercial schools seek hospital affiliation and some claim they already have it, but these claims do not always hold up. The College of Medical Technology in Minneapolis had a statement in its catalog that "Hospital internship is offered to advanced laboratory and x-ray students at the close of their training. Internships are available at several hospitals." But when Jerome Feist, placement director of the College, was questioned about this a couple of years ago, he admitted there actually are no hospitals where students are placed regularly. Some schools put the burden of proof on the students by giving Certificates of Attendance at the end of the course but withholding diplomas until the former students can show that they have done six months' satisfactory work (voluntary or paid) in a clinical laboratory. The student thus gets

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practical training and the school gets a letter from the hospital administrator or laboratory chief saying the student's work is satisfactory. This can then be published as part of the school's promotional literature.

Several years ago Carnegie in Cleveland tried out a plan by which a hospital could advance $1200 on a student's tuition, which the student would pay back by a two-year internship at the hospital. "The only trouble with this plan," according to one hospital administrator who didn't try it, "is that in the end we would not only be paying the student's tuition at Carnegie, but training him when he got through." Some county medical societies have allowed schools to offer "scholarships" in their names, a partial waiving of tuition that more than pays for itself in publicity, thus by implication putting the society's stamp of approval on the school.

Who hires commercial school graduates? A corollary to this question should be "What are they given to do and how much retraining is necessary?"

Often private doctors hire them for a combination medical secretary-technician role. Private laboratories hire them, and nobody knows how much responsibility they are given. According to an AMT survey, the big employers of medical laboratory personnel, the hospitals, employed 3682 AMT registrants in 1960, but there was no breakdown as to where they were trained or what they did on the job.

As a rule, when big urban hospitals hire commercial school graduates they are usually given limited assignments with considerable supervision, until they can be retrained. In rural areas, however, commercial school graduates can be found running the laboratory.

These facts were brought out in a statewide survey of clinical laboratory services in 145 hospitals in Minnesota in 1959, which showed that current shortages among medical laboratory personnel are forcing rural hospital administrators to take what they can get. As a result, in Minnesota, where three-quarters of the hospitals surveyed were rural, a large proportion of the technical supervision of the laboratories was being done by high school graduates with some laboratory training. Such hospitals often are unable to obtain the supervising services of pathologists, also in short supply.

Interviewed by the *Minneapolis Tribune* in November 1960, Edwin Hetland, director of the College of Medical Technology in Minneapolis, admitted that most graduates employed by doctors and hospitals had jobs in rural areas where it is difficult to get the graduates of regular colleges and universities to go. In the same newspaper, hospital pathologists interviewed said they did little or no hiring from among the graduates. The group interviewed included:

Dr. Martin A. Segal, chief pathologist of Methodist Hospital in St. Louis Park, Minn.: "I will hire medical technologists registered by the American Society of Clinical Pathologists and laboratory assistants trained by the University of Minnesota. I will also take high school graduates and teach them specialized duties. I will not hire any of the one-year graduates from commercial schools, as their training has been of insufficient caliber to permit their being of use in a hospital laboratory."

Dr. Steven Barron, Mount Sinai, Minneapolis: "We hire them on a very limited basis. Only a few. And they do elementary things. We retrain them in our own technics. We call them laboratory aides, not technicians. We let them draw blood and do electrocardiograms and things like that, all of which we can recheck. We make it clear to them we do not regard them as technologists or even as technicians. We hire them only as a matter of necessity, because we need the help for routine jobs."

Dr. John Coe, Minneapolis General: "We hire no such students at all for medical technology work. We may use them as dishwashers, but not as technical persons."

Dr. Fred Lott, Northwestern Hospital: "We never hire them, not even as dishwashers."

While graduates have a hard time getting jobs in reputable clinical laboratories, few states have laws which prevent these graduates from opening up their own private laboratories, and many do. As of 1961, 630 members of the American Medical Technologists owned private laboratories, whereas only 587 were employed in private laboratories.

Some indication of the extent of privately owned clinical laboratories comes from New York City, where the health department has examined 395 such laboratories, and found only 62 operating in a completely satisfactory manner. All the rest required either performance tests or some kind of follow-up, and of these 32 were put out of business.

Commercial schools want state licensure or approval, at their own level, for a good many reasons.

This spring they called on the U.S. Public Health Service (for general approval), on the U.S. Office of Education (to find out how to get the Accrediting Commission officially reorganized), on the Women's Bureau of the U.S. Department of Labor (for listing in the Occupational Outlook Handbook) and on the U.S. Department of Health, Education and Welfare (to ask that Secretary Ribicoff or someone from his office represent officialdom at their annual meeting).

The U.S. Department of Labor agreed to list AMT as a source of information on medical technology schools in "Occupational Outlook," a handbook of career information published bi-annually and widely used by vocational advisers and by state and local employment and training agencies.

Official approvals at the state level have been worth a lot of money to the private schools of medical technology. In fact, it was the G.I. Education Bill that propelled a good many of them into existence. Once a school is approved by its state approval agency for the Veterans Administration, tuition for eligible vets is underwritten. The same holds true for vocational rehabilitation grants to the physically handicapped. Here again, the school must be approved by the Vocational Rehabilitation Bureau for each state.

With the number of veterans seeking educational aid on the wane, the physically handicapped have become important with commercial schools. Franklin School of Science and Arts in Philadelphia has approval from

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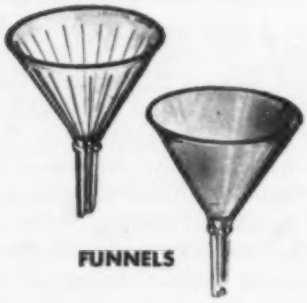

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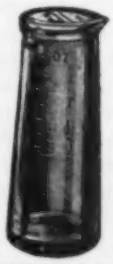

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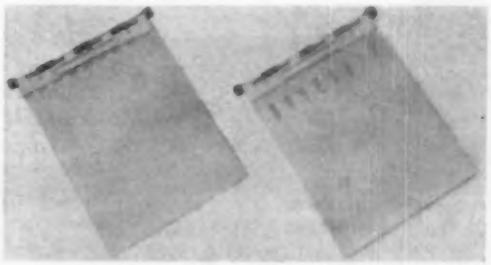

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Pennsylvania, New Jersey, New York, Maryland, West Virginia, North Carolina and Georgia. Eastern School for Physicians' Aides in New York taps most of these states and reaches as far north as Vermont.

Many commercial schools also seek approval from the regional offices of the U.S. Immigration and Naturalization Service, which permits the school to enroll non-immigrant students from outside the United States. This is becoming increasingly profitable as U. S. foreign policy encourages student exchange.

But the schools do not always have it their way. Some schools have been denied veterans' approval, not once but several times. In Minnesota, where the State Commissioner of Education, Dean M. Schweickhard, has been extremely alert to the commercial school problem, the College of Medical Technology applied for veterans' approval twice in 1954 and again in 1956 and was turned down. In 1960 this same school lost its federal approval as a school which non-immigrant foreign students may attend. Just recently, Great Lakes College in Detroit applied for and was refused approval to train foreign students by the U. S. Immigration and Naturalization Service regional office in Detroit.

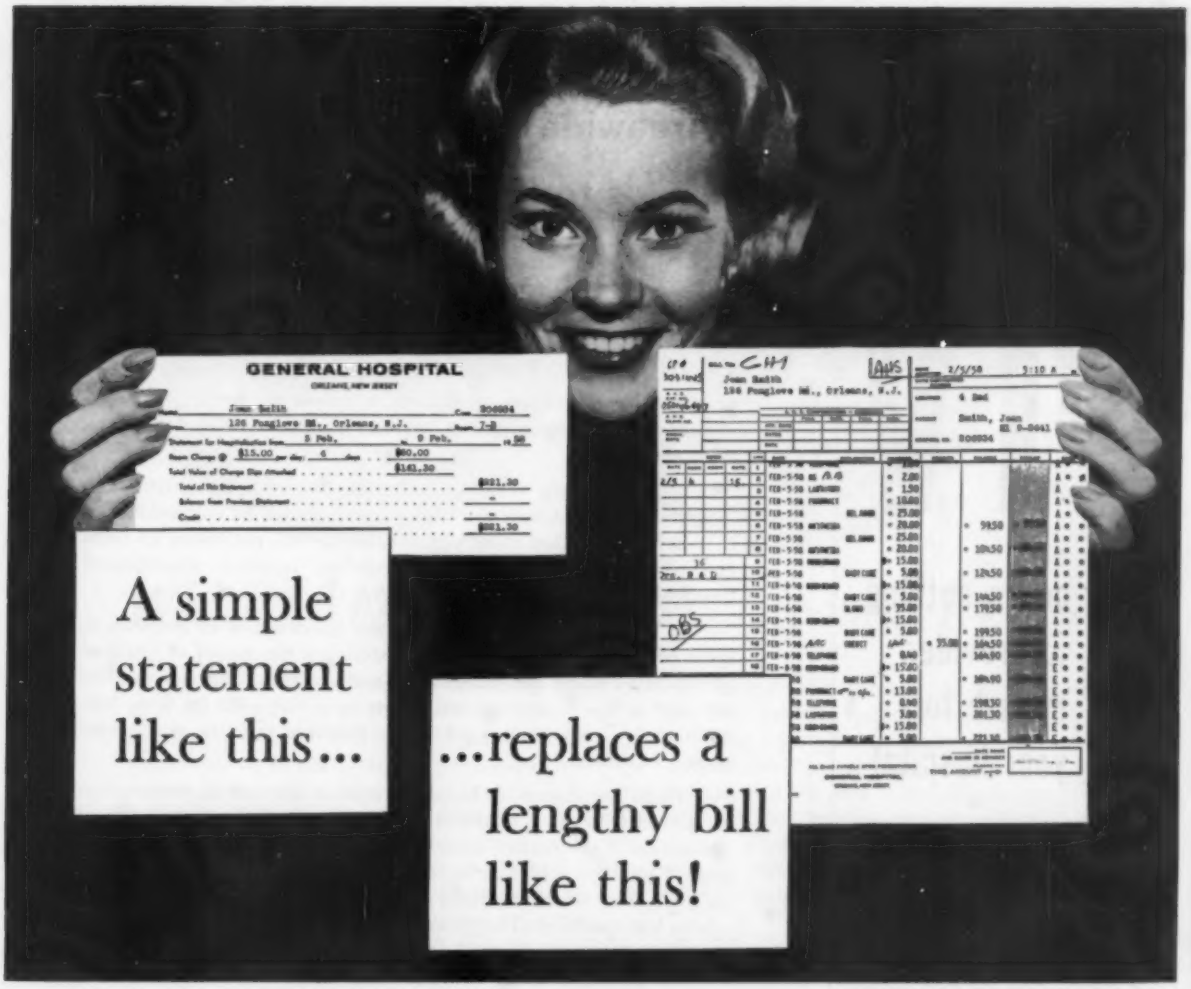
As a result of a combined effort by officials of the state office of education, the High School Counselors Association, the state pathology and medical technology societies and the press, in April the Minnesota state legislature passed the Trade School Bill, bringing under state regulation the claims of accomplishment made by such institutions. To qualify for registration, trade schools must have sound financial structure, adequate training facilities, qualified instructors and proper sanitary conditions. The law became effective in September.

In Massachusetts in 1955 a law went into effect specifying that "no person shall operate or maintain a school for training medical laboratory technologists unless such school has been approved in writing by the Approving Authority." In 1959, when the attorney general sought petitions to restrain Carnegie Institute in Boston from giving further courses in medical and x-ray technology and to have a receiver appointed for the school, the judge issued a temporary restraining order enjoining Carnegie from disposing of any assets, and public hearings were held. Now the case is on the docket for Superior Court.

It takes a lot to close a school permanently, although this seems to have been achieved in Chicago in 1957 when the State Department of Education and Registration investigated the Century College of Medical Technology, which in addition to day and night school offered a correspondence course. Investigators visited the school, examined faculty, records, teaching methods, equipment — and former students. They reported that teaching consisted mostly of reading out of a textbook, with little or no demonstration; laboratory tests were practiced on samples taken from students including gastric juices obtained through stomach tubes, and while gastric tubes and needles for blood tests were boiled, instruments were handled and procedures were unsanitary. In fact, the whole school — equipment, walls, floors and laboratory furniture — was described as "unbelievably dirty."

Students were, however, excused from class to scrub the place just before pictures were taken for the school catalog. Likewise, although a requirement to wear laboratory uniforms was not usually enforced, everyone was reminded to wear a white one the day the school was inspected for veterans eligibility. This attempt to put a clean face on everything was evidently successful, since until the school was closed, Century had approval for G. I. training, as well as from the U. S. Immigration and Naturalization Service for non-immigrant foreign students.

Although Century College went out of existence before the AMT-sponsored Accrediting Commission for Medical Technology Schools was formed, some of its graduates carry on in the faculties of other "accredited" commercial schools. In fact, the one former student interviewed by the State Department of Education and Registration who appeared to be satisfied with her training subsequently became assistant director of the "accredited" Chicago School for Medical Technicians (*Lab World*, February 1959), as well as FACMT, DABB-A, a recipient of AMT's Distinguished Achievement Award, Exceptional Meritorious Award, holder of numerous AMT offices, and secretary of the ART. ■



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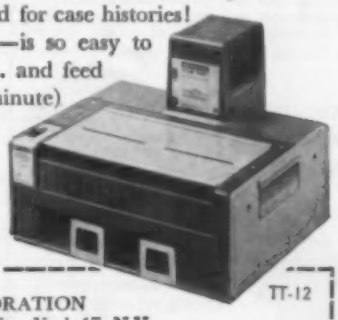

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Areawide Planning for Hospitals Leads to Good Medical Services

By Robert S. Myers, M.D.

A RECENT publication* stresses the most critical need in the health care field today. This is the absence generally of any practicable and effective mechanism to ensure the intelligent development and the logical use of hospital facilities and services on an areawide basis.

It is heartening that the authorities are now recognizing this deficiency and that they are urging measures for its correction. But it is unfortunate that more vigorous action was not taken 15 years ago when the spate of small, nonurban hospitals mushroomed throughout the country after World War II.

In particular, one must regret the construction of hospitals in areas where neither the community needs nor the supply of qualified physicians justified the building of costly plants. This has resulted not only in low occupancy and higher operating costs for some hospitals, it has also encouraged the undesirable practice of itinerant surgery in others.

There are numerous hospitals, located not too far from urban areas, which have no qualified surgeons, particularly in the surgical specialties. If the patient needs surgery, he must either travel to the nearest medical center or a surgeon must be imported to do the surgery, after which he turns the vital postoperative care over to others less qualified. This is contrary to the welfare and safety of the patient, yet the hospital cannot exist financially if the community's surgical patients go elsewhere.

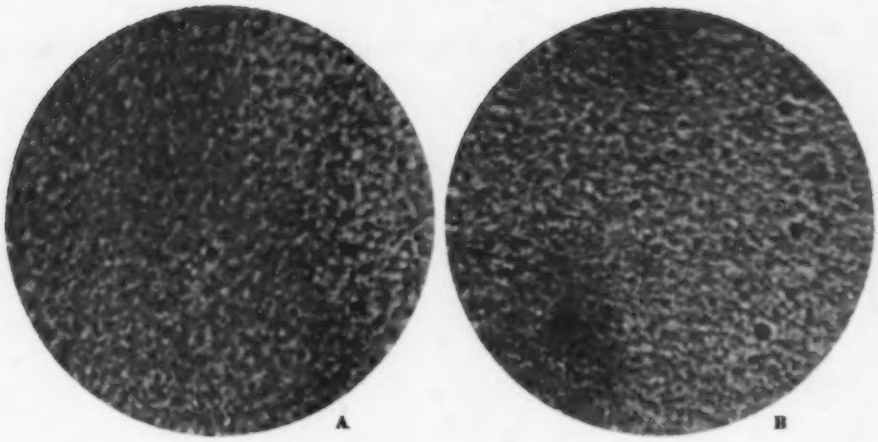
Consider the number of communities, large and small, in which identical, costly, low-volume services are maintained in several hospitals, some of which are contiguous.

One example of such unnecessary duplication is the cardiac surgery service which so many hospitals covet, in spite of the horrendous cost of equipment, facilities and specialized personnel. The result is that a few complicated cardiac operations are done in each hospital at an exorbitant cost per case to the hospital. Such duplication is not necessary for quality care in the hospital.

What is needed is concerted and determined planning to prevent construction of hospital beds in areas where they are not necessary. What is also needed is some method of stopping the unnecessary duplication of hospital services. It should be possible to develop an integrated referral system, acceptable to patients and doctors, whereby patients will be referred for certain care to specialists who are located in the medical centers in that area which are equipped to handle complicated problems.

All this will require intelligent and detailed evaluation of an area's needs; it will also require considerable education of the public and of the medical profession; and, finally, as the interesting little publication hints at so delicately, it will demand some effective means of withholding the money from hospitals that will not cooperate. ■

*Areawide Planning for Hospitals and Related Facilities — Report of the Joint Committee of the American Hospital Association and Public Health Service, July 1961. Public Health Service Publication No. 855.



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‡*1 cc.—approximately 20 drops.*

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Reactions of a "colloid" type may occur, including back or chest pain, dyspnea, severe flushing, or urticaria. There may be delayed chill. Transient fever has also been noted, as have such other minor reactions as nausea, vomiting, abdominal discomfort, headache, mild flushing, dizziness, and some variations in blood pressure and pulse.

When the recommended dosage is exceeded, an "overloading syndrome" may occur characterized by chill, fever, abdominal pain, nausea, vomiting, hepatomegaly, clotting defects, thrombocytopenia, and bleeding, particularly from the gastrointestinal tract.

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Hospital Pharmacy Attracts, But Fails To Hold, Recent Graduates

Grover Bowles Jr.

ALTHOUGH increasing numbers of recent pharmacy graduates are practicing in hospitals, relief from the chronic shortage of hospital oriented pharmacists is not in sight.

Grover Bowles Jr.

Reliable turnover figures are not available. We do know, however, that as a group, hospital pharmacists are highly mobile. This is owing in part to the influx of young pharmacists who enter hospital practice each year on a more or less trial basis before they arrive at a firm decision regarding the specialty of the profession they will eventually pursue. Then, too, hospital pharmacy attracts a sizable number of young women. Many of these young women will interrupt their careers with marriage and family responsibilities. Some will retire permanently, others only temporarily, picking up their careers in later years.

Preliminary reports of the Audit of Pharmaceutical Service in Hospitals show that one-third of the pharmacists now practicing in hospitals are less than 30 years of age and have been in hospital pharmacy for less than three years. More significantly, one-half of all pharmacists practicing in hospitals are under 40 years of age and have been employed in hospitals for less than six years. This clearly indicates that hospital pharmacy is now attracting respectable numbers of recent graduates. What is not revealed is the number of young as well as mature pharmacists leaving the hospital field each year. Some become hospital administrators, some continue graduate education leading to other pursuits, and more enter the pharmaceutical industry and the community practice of pharmacy.

Why this continual loss? Some of it is owing to the lack of interest and failure to see the challenge in hospital pharmacy, but for the most part it is because of the lack of adequate pay.

For too long hospitals have used desirable working conditions, shorter hours, and fringe benefits in lieu of salary to attract pharmacists. Only in most recent years have hospital pharmacists' salaries begun to equal the going rate in the community. This is not enough to attract and hold pharmacists having the attributes, education and training required to keep pace with the increasing complexity of drug therapy and pharmacy operation.

The *British Pharmaceutical Journal* recently put it this way, "The plain fact is that men of the caliber required for such posts are not to be found in the service. They can command better salaries in industry or teaching if their interest lies in scientific work, and they can certainly fare better financially in retail if their interest lies there."

There are over 110,000 pharmacists in the United States, with only about 5 per cent of them practicing in hospitals. Historically, the total number of pharmacists has been rather constant. With the recent increase in the educational requirements and the additional years of experience required for the development of competent pharmacists it is unlikely that the total number available will keep pace with population increases. In addition to good pharmacy facilities and security, salary commensurate with ability and the responsibilities assigned will be required by those hospitals that expect to get their share of the able pharmacists available. ■

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Operating Room Forum

Hospitals, Not Surgeons, Should Provide All Surgical Instruments

By Frances Ginsberg, R.N.

THE history of surgery tells us dramatic stories of the itinerant surgeon who traveled where he was needed. In homes he usually used the kitchen table for operations.

Frances Ginsberg

If a hospital were available, the surgeon sometimes used whatever space was provided to perform his surgery. It was an obvious necessity that he own his own instruments and carry them with him.

As hospitals were built and the technics of surgery improved, the kitchen became obsolete as an operating theater, and hospitals began to provide more adequate and acceptable space for surgical procedures.

With the expanding knowledge of surgery, anesthesia and asepsis, the operating room became a necessity and a carefully equipped and controlled area. Its equipment and personnel became more and more specialized, the better to assist the surgeon.

Today few areas lack adequate surgical facilities, either in their own communities or immediately available. However, the old practice of the surgeon acquiring, owning and using his own instruments has persisted in many areas.

This antiquated practice is not only a constant source of annoyance, problems, trouble and expense to the hospital, the surgeon, and the operating room staff, but also a deterrent to good surgery and a danger to patients.

When each surgeon either brings his own instruments to the hospital or has them stored for his exclusive use at the hospital, hospital personnel must be responsible not only for their sterilization, but also for their separation, intact storage, and full inventory.

Separating the instruments, seeing that they are in good condition, and then storing them requires, in addition to time and space, the constant concern that they are neither lost nor mixed with another surgeon's set. Time and space cost money. Mistakes often result in tensions, anxieties and bad relationships; although these cannot be measured in dollars and cents, they are expensive in terms of morale.

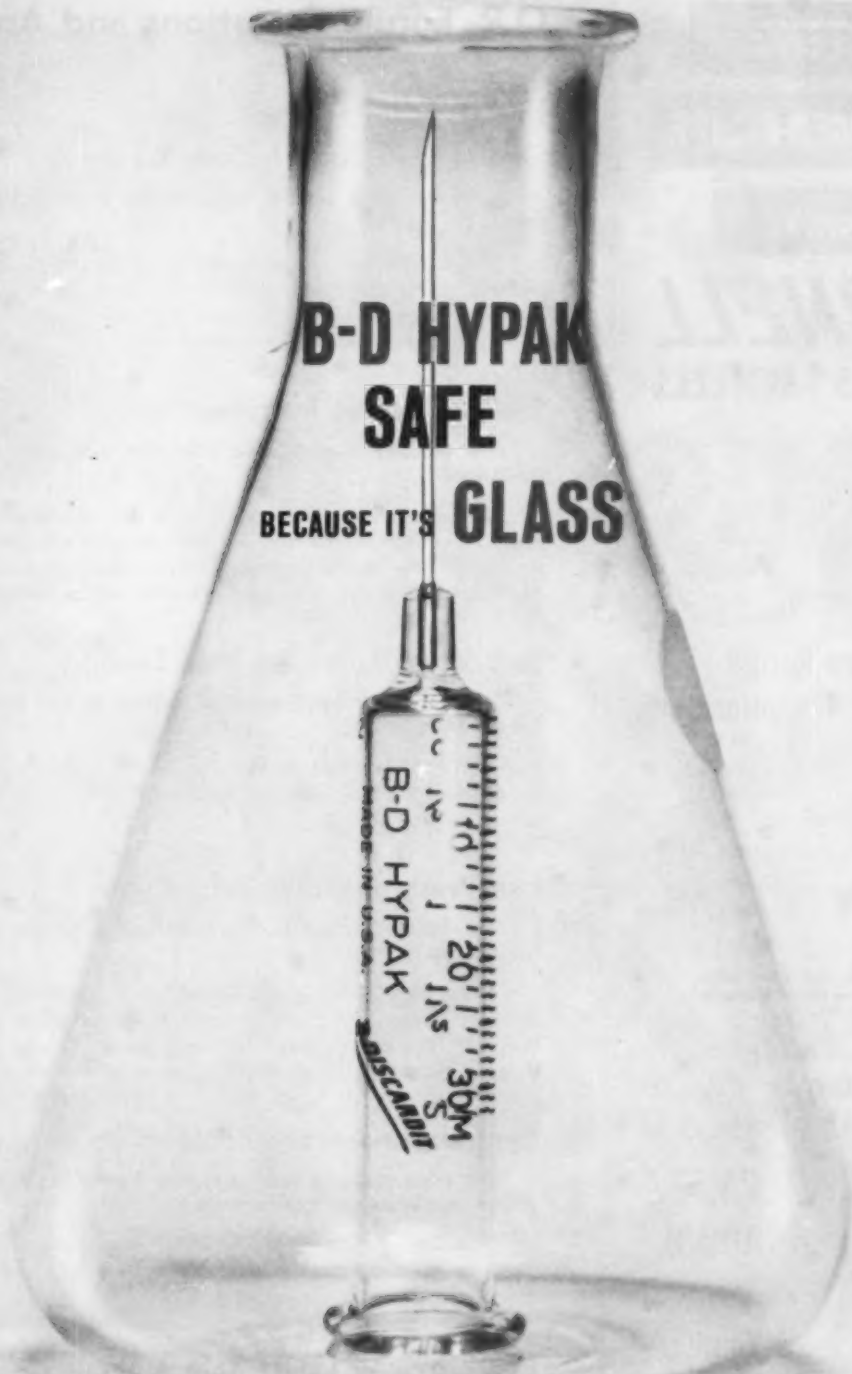
As if these facts are not enough argument against this practice, it is obvious that few surgeons can or will continue to provide themselves with a sufficient quantity of instruments of the quality and variety which modern surgical technics demand.

Surgeons are also sometimes reluctant to dispose of obsolete instruments for fear they might possibly need one of them. In the face of these problems, this situation persists in too many hospitals.

It is my belief that all hospitals should not only provide adequate operating areas and staff, but also should provide all instruments needed by all surgeons operating in that hospital. The surgeon, on the other hand, should be willing to accept this idea not only for his own benefit but for the benefit of the hospital, its staff and, for the most apparent reason, for his patients as well. ■

(*O.R. Questions and Answers Appear on Page* 120)

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.



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O.R. Forum Questions and Answers

Should O.R. Suite Include Castroom?

Should we include provision for a castroom in planning our new O.R. suite?

No. A castroom should be located elsewhere in the hospital, preferably near the emergency room or x-ray facilities. Dirt, dust and bacteriological hazards demand that only those casts required by surgery be applied in an operating room.

Sterilize Septic Instruments First

Is it necessary to clean septic instruments from patient units before sterilization?

It is not only unnecessary, it is not even advisable. Safety demands that instruments used on isolation patients should *first be sterilized* in the muslin or paper sacks in which they are prepared. They should then be cleaned and checked before resterilization.

Sort Ward Linen To Help Laundry

Should ward linen soiled with blood be rinsed by ward personnel before it is sent to the laundry?

No. By doing this, both the worker and the environment are jeopardized. To help the laundry, the "bloody" and "dirty" linen should be separated.

Use Presterilized Mineral Oil

How should we sterilize 30 cc. of mineral oil? Please give time, temperature and exhaust cycles.

Since mineral oil is anhydrous, it is admittedly difficult to sterilize. Sterile liquid petrolatum is now commercially available in 10 cc. screw-capped jars. If this is used, the considerations of time, temperature and exhaust are of no concern.

Central Service Should Sterilize Basins

With only a small high-speed autoclave in the operating room, how can we sterilize large basins after a contaminated case?

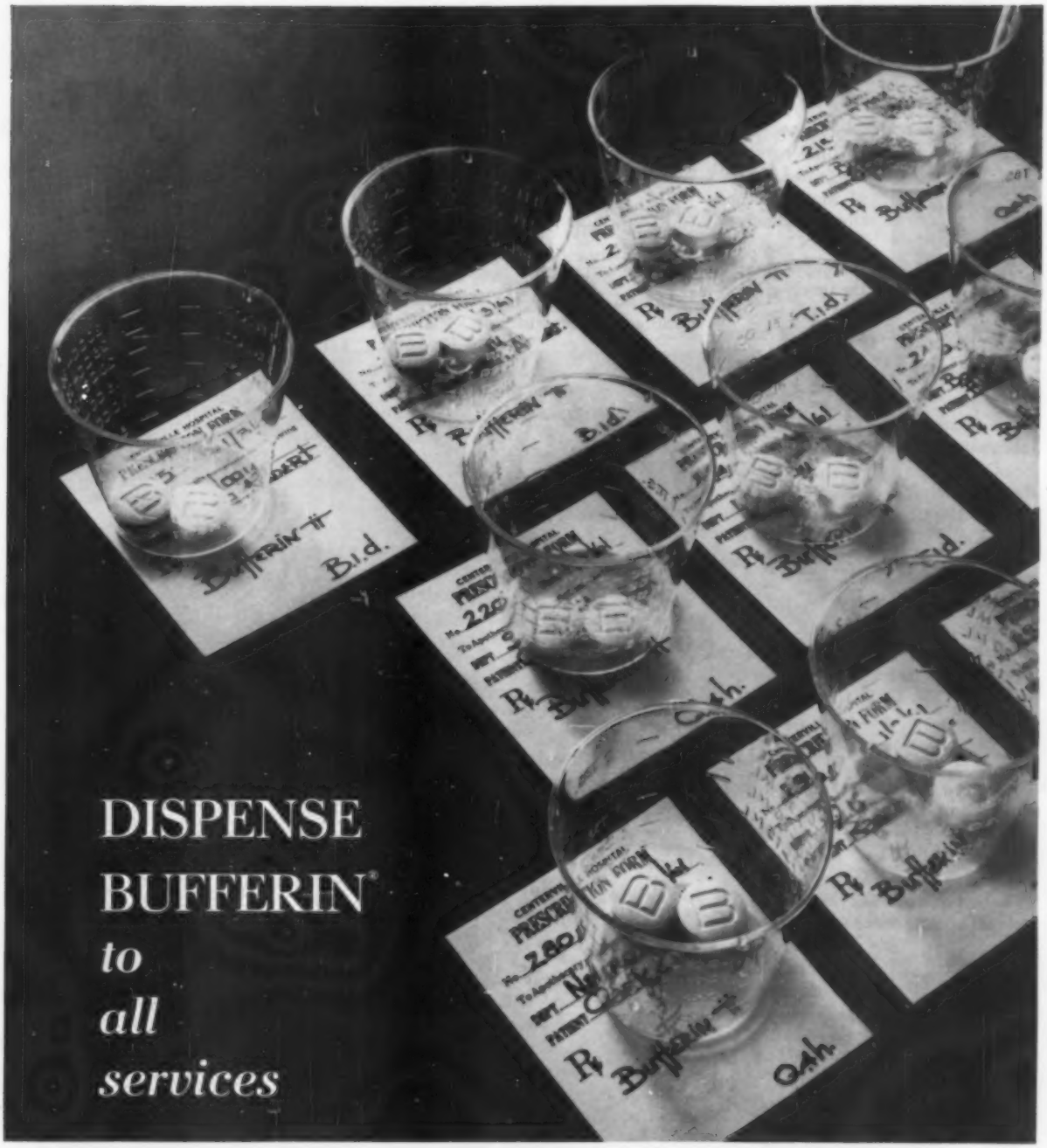
Wrap them in a clean pillowcase, laundry bag, or paper sack and send them to central service for sterilization before further handling.

Polyethylene Liners Safe — If

Is it safe to use polyethylene liners in kick buckets in the O.R. and in the delivery room?

Yes, provided the liner is moistened in water before being inserted in the bucket. This should be done during the preparation period before each case begins.

Questions regarding operating room practice will be welcome and will be forwarded to Miss Ginsberg for reply in this column.



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ABOUT PEOPLE

Administrators

Dr. Leonard D. Fenninger, associate dean of the University of Rochester School of Medicine and Dentistry, Rochester, N.Y., has been appointed to the newly created post of medical director of Strong Memorial Hospital in Rochester. His responsibilities will include those formerly assigned to the acting administrator, **Dr. Robert L. Berg.** Dr. Fenninger received his M.D. from the University of Rochester Medical School (1943). He is a member of Phi Beta Kappa, the American Medical Society, and the American Association for the Advancement of Science.

Dr. Fenninger

Harvey H. Weiss has resigned as executive director of Sinai Hospital of Baltimore, Inc., Baltimore, after more than 40 years in administrative work. He was graduated from Ohio State University. Last year Mr. Weiss was cited for his contributions to the field of health by the Maryland-D.C.-Delaware Hospital Association, an organization which he served as president for two terms. He has also served on many state and local planning and health commissions.

Robert W. Lyons has been appointed administrator of Riviera Community Hospital, Torrance, Calif. For the last two years he has been administrator of The Westwood, West Los Angeles. A graduate of Northwestern University's program in hospital administration (1952), Mr. Lyons is a fellow of the American College of Hospital Administrators.

Robert W. Lyons

Thomas A. Harrington has been named administrator of Mary Lane Hospital, Ware, Mass. Mr. Harrington received his M.P.H. in hospital administration from Yale University (1956). Formerly, he was associate administrator of Pittsfield General Hospital, Pittsfield, Mass.

Sister Mary James, administrator of Stork Memorial Hospital, Huntingburg, Ind., has been reassigned to St. Benedict College, Ferdinand, Ind.

Frank P. Mazza has been appointed administrator of Doctors Hospital, Pittsburgh. Formerly, he was administrative assistant at Citizens General Hospital, New Kensington, Pa.

Donald J. Jacobs has accepted the position of administrator of Woodlawn Hospital, Chicago, succeeding **Ernest L. Bliss,** who resigned to join the staff of the University of Chicago's real estate division. Mr. Jacobs, a graduate of Northwestern University's program in hospital administration (1957), formerly was assistant executive director of the Chicago Hospital Council.

Donald J. Jacobs

John A. Taft Jr. has been named administrator of Delnor Hospital, St. Charles, Ill., succeeding **Cora Radke,** who has been appointed administrative consultant to the board of trustees of Delnor Hospital. Mr. Taft received his M.S. in hospital administration from Northwestern University (1957).

Elvin D. Arnoldy has become administrator of Kaiser Foundation Hospital, Vallejo, Calif., succeeding **Henry Kaye,** who resigned. At the same time it was announced that **Daniel Fletcher** will succeed Mr. Arnoldy as administrator of Kaiser Foundation Hospital, Richmond, Calif. Mr. Fletcher received his master's degree in hospital administration from the University of California.

Mary V. Gordon has assumed the post of administrator at Sunnyside General Hospital, Houston, succeeding **Howard E. Troutt.**

Sister Mary Grace, R.N., has been appointed administrator of St. Anthony Hospital, Oklahoma City, succeeding **Sister Mary Agnes, R.N.,** who has been transferred to Mount Alverno Convent, Maryville, Mo. Sister Mary Agnes is a past president and trustee of the Oklahoma Hospital Association, and a founding member of the Oklahoma Conference of Catholic Hospitals. Sister Mary Grace received a master's degree in hospital administration from St. Louis University.

Dr. Albert E. Pugh has been named director of the Veterans Administration Hospital, Clarksburg, W. Va. He received his M.D. degree from the University of Kansas (1941). Formerly, he was chief of staff at Veterans Administration Hospital, Durham, N.C.

Harvey M. Radey Jr. has been elected administrator of Josiah B. Thomas Hospital, Peabody, Mass., succeeding **J. Leo Ash.** Mr. Radey, a graduate of the University of Toronto's program in hospital administration (1952), formerly served as administrator of Maine Coast Memorial Hospital, Ellsworth, Me.

Gus Champagne has been appointed administrator of St. Charles Parish Hospital, Luling, La., succeeding **Lester J. Madere.** Mr. Champagne was formerly a member of the hospital's board of directors.

Col. Sam A. Edwards has been named director, Department of Administration, Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Tex. A graduate of Northwestern University's program in hospital administration (1952), Col. Edwards formerly was special projects officer, surgeons section, Korea.

Glenn V. Bailey has resigned as administrator of Grand View Hospital, Sellersville, Pa., to become administrator of Montana Deaconess Hospital, Great Falls, Mont. He is a graduate of Columbia University's program in hospital administration (1955).

James D. Putnam has been appointed administrator of the new Jackson Parish Hospital, Jonesboro, La., scheduled to open in March 1962. Mr. Putnam formerly was administrator of DeSoto General Hospital, Mansfield, La.

Dewitt Allsup has been named administrator of the new Archer County Hospital, Archer City, Tex. Formal opening of the hospital is scheduled for the beginning of January 1962.

(*Continued on Page* 173)

Internal hernia through the foramen of Winslow with partial chronic intestinal obstruction

Radiographs on Kodak Blue Brand Medical X-ray Film; surgery photographed on Kodak Ektachrome Film

As the radiologist saw the case . . . Figure 1: Demonstrates compression of lesser curvature of the stomach by fecal matter in the colon. **Figure 2:** Some barium has now entered the portion of the colon which has herniated into the lesser sac. **Figure 3:** Demonstrates cecum and ascending colon in the lesser sac and constriction of the colon where it passes through the foramen of Winslow.

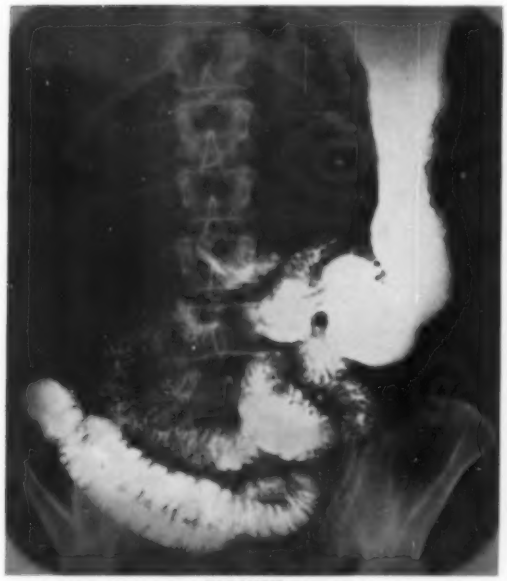

FIGURE 1

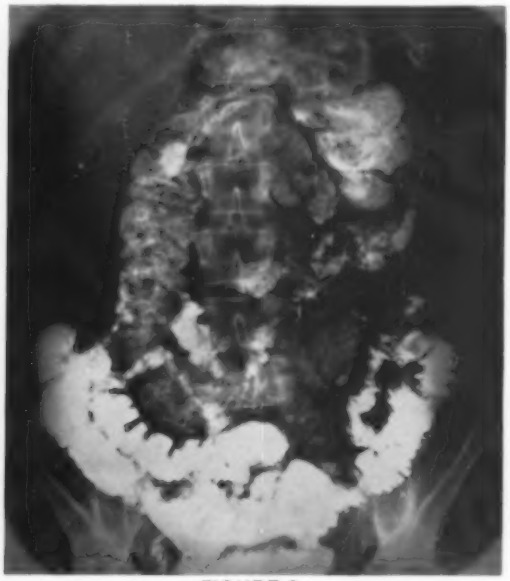

FIGURE 2

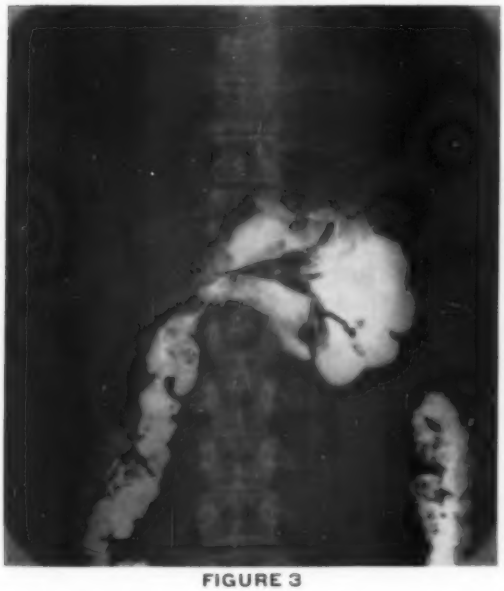

FIGURE 3

The surgery which followed—step by step —Figure 4: Demonstrates proximal dilated loop of colon disappearing into the foramen of Winslow. *For further photographs and notes on surgery, turn page.*

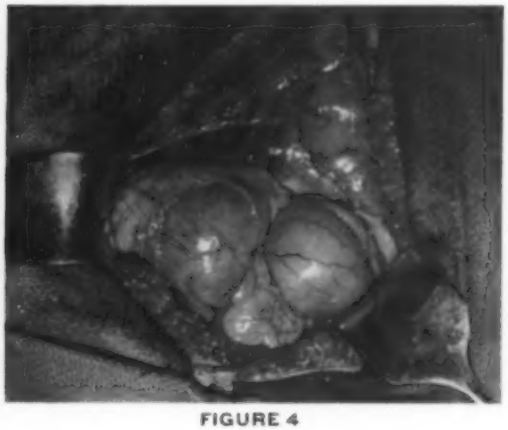

FIGURE 4

Internal hernia. *Radiographs and first step in surgery are shown on preceding page.*

Definitive, completely objective. That is the reason why photographs play such an important part in teaching; why their value is so great as a record and for research.

With color slides, motion pictures, or color prints, for example, complicated procedures are more readily explained, more easily understood, more memorable. What's more, the material you show today may be used over and over again. Yet its cost is surprisingly small.

FIGURE 5

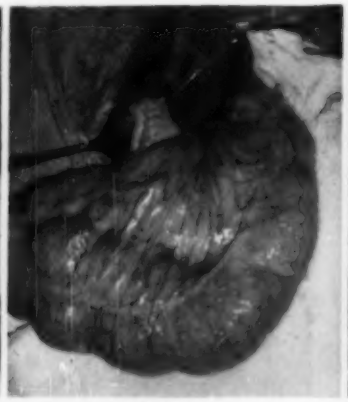

FIGURE 6

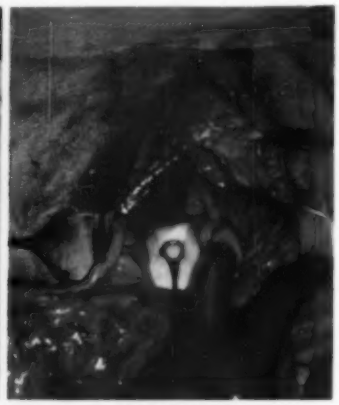

FIGURE 7

FIGURE 8

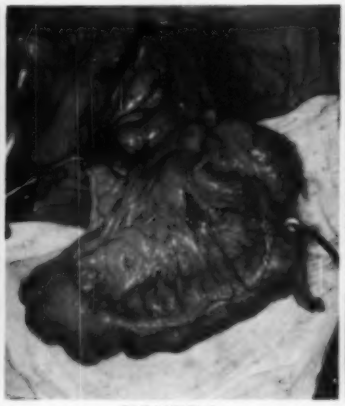

FIGURE 9

FIGURE 10

Figure 5: Appendix has been withdrawn from the lesser sac.

Figure 6: Mobile ascending colon now withdrawn from lesser sac. Note ecchymosis in mesentery which was constricted at the foramen of Winslow.

Figure 7: Demonstrates portion of omentum adherent in lesser sac.

Figure 8: Adherent portion of omentum has been sutured and divided.

Figure 9: Demonstrates extreme mobility of ascending colon with its long mesentery and constricted area in colon.

Figure 10: Foramen of Winslow has been narrowed by sutures.

Conducted by Jane Hartman

Reports From the A.D.A.

Dietitians Get a Large Helping of Food Management Technics

ST. LOUIS. – Food and food service were nearly relegated to the exhibition hall – and the dining rooms – at the annual meeting of the American Dietetic Association here October 24 to 27. In the assemblies and meeting rooms the dietitians pondered such managerial problems as personnel relations, cost accounting, equipment specifications, and the psychology of menu planning.

It was obvious that dietitians are expected to become as familiar with the accounts book as they are with the cookbook. "Planned control of the hospital food service budget is one of the first responsibilities of the dietitian as a manager," one speaker reminded.

The speaker, Lt. Col. Ruby Z. Winslow, chief of the food service division at Walter Reed General Hospital, Washington, D.C., went on to describe how pay scales are determined in the army food service.

Pointing up the goals for civilian departments as well, Col. Winslow stated: "To keep the man on the job requires careful initial selection and the good health, morale and job satisfaction of the individual, as well as a fair pay rate and an opportunity for promotion. . . . Pay management cannot be divorced from the personnel policies and management of the department."

Recognition of the dietitian as a manager was emphasized even more strongly by a hospital administrator. "The professional dietitian in food service management is measured first as a manager of people and things; and second for her technological and scientific knowledge," according to John J. Zugich, assistant director of University Hospital, Ann Arbor, Mich.

He described as the dietitian's most difficult task "the management of groups of people, of funds in her trust, and of dietetic 'hardware' toward a goal of scientific, psychologic and economic food service."

Describes Basic Tools

Two of the tools used in this task – specifications and inventory – were described by Aimee N. Moore, Ph.D., director of nutrition and dietetics at the University of Missouri Medical Center, Columbia.

She made the whole thing sound almost easy when she described a specification as "merely a list of the specific characteristics desired in a product for a specific use."

In justifying the use of a perpetual inventory, the speaker noted some of the "hidden" costs of carrying large inventories. They included: loss of perishable items, utilization of space that might be freed for productive purposes, labor costs of handling and maintenance, heat, light, refrigeration, taxes, insurance.

Food did get mentioned, of course, but often as not it was in terms of technology or therapeutics. Exemplifying the managerial approach to food was the address by Lendal H. Kotschevar, Ph.D., on convenience foods.

Dr. Kotschevar, professor in the school of hotel, restaurant and institutional management, Michigan State University, described how the benefits of mass production, standardization and specialization might result from the use of convenience foods.

Recent tests at Michigan State University, he reported, indicated that in general there was no significant difference between the acceptability of boil-in-the-bag foods and conventionally prepared foods.

The time required to produce the 10 conventional foods tested was 11 hours and 30 minutes, compared to 14 minutes for the 10 precooked foods, Dr. Kotschevar reported.

In another address on prepared frozen foods, it was reported that studies on the microbiology of such foods indicated that food poisoning organisms do not grow at temperatures below 40 F. Consequently, it was noted, there is no danger of food poisoning if the precooked foods are not allowed to incubate above this temperature.

However, a survey carried out recently by the U.S. Food and Drug

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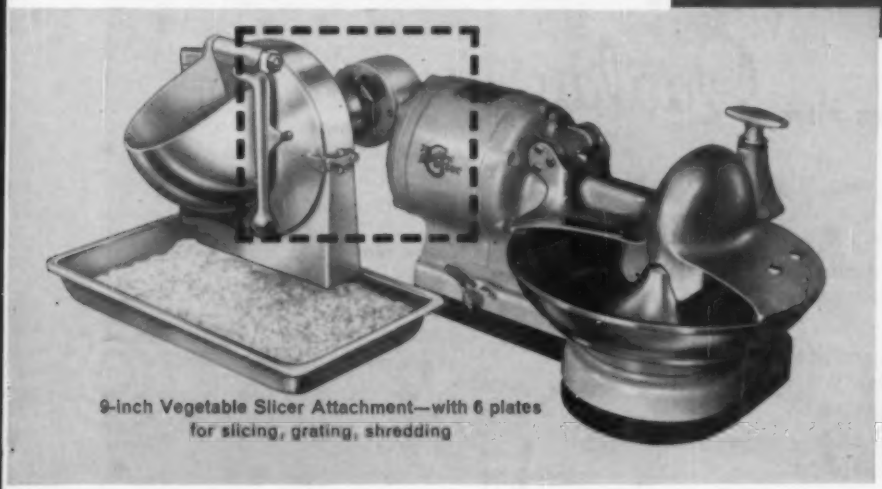
Each attachment gives you an added food preparation tool *at a cost far less* than a separate self-contained unit. The more attachments you use, the greater the productivity, economy and menu-variety ...and you get the greatest possible return on your Hobart machine investment. Get full details. Write **The Hobart Manufacturing Co., Dept. 306, Troy, Ohio.**



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Administration disclosed that some of the precooked frozen foods now on the market were not as low in bacteria as might be desired, the report continued.

"In June, the Association of Food and Drug Officials of the United States unanimously passed a code to 'govern' the packing, transportation and handling of frozen foods," reported Donald K. Tressler, Ph.D., president of Avi Publishing Company, Westport, Conn.

Bacteriological levels were not specified, he said, inasmuch as they are "still under investigation and have not been established."

Regardless of what is done, he concluded, "there is little doubt that there will be a notable improvement in conditions under which frozen precooked foods are prepared, packaged and transported."

A selective menu seems to be most important to women patients and those with prolonged hospital stays, according to the report of one study in a small hospital. The primary purpose that it serves is an increased personal attention to the patient.

When a visiting dietitian was assigned to an area of more acutely ill patients and patients with shorter hospital stays, the investigators found that demands for a selective menu declined.

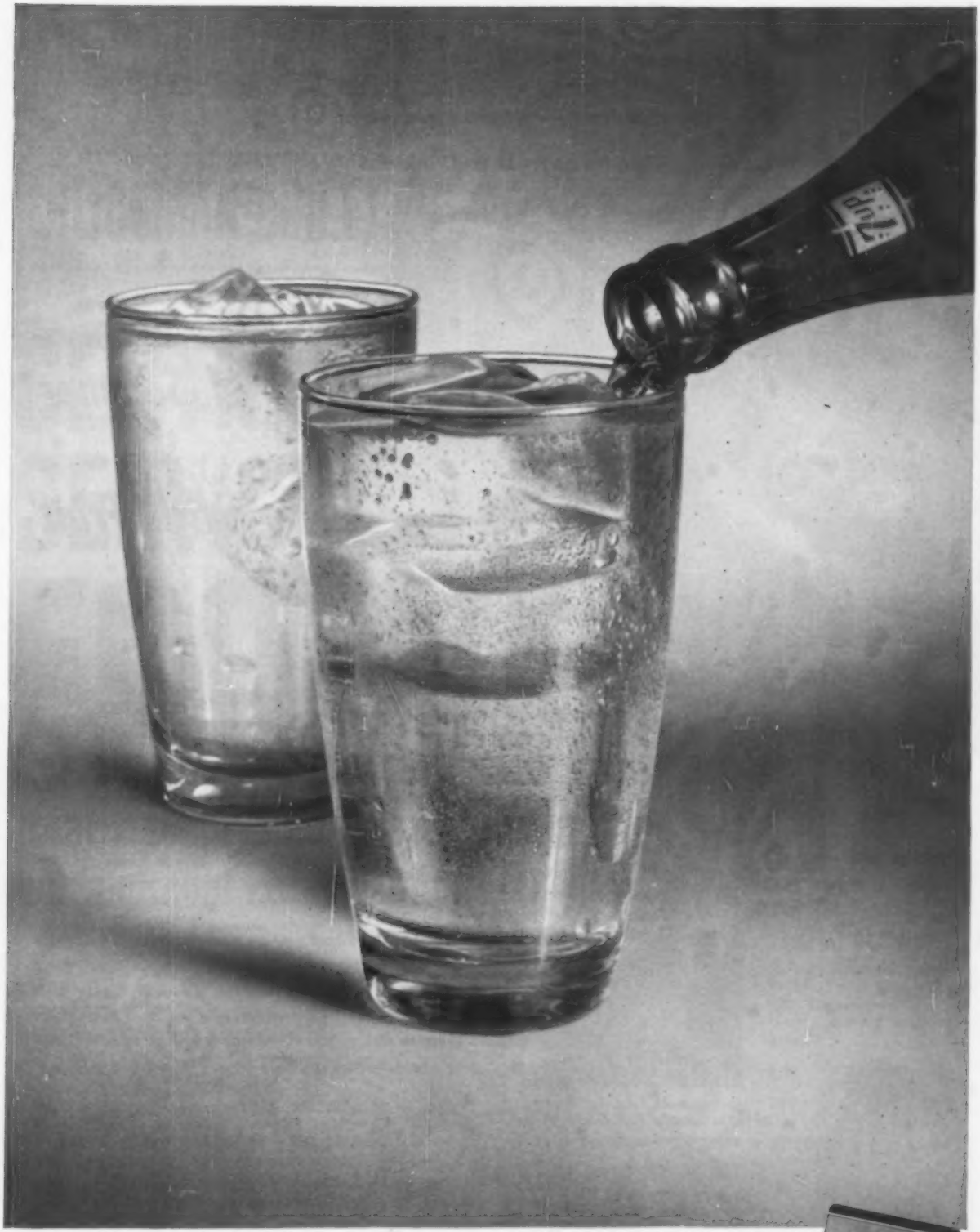
No difference in nutrient intake was observed between the groups using and not using the selective menu. The study was reported by Margaret A. Ohlson, Ph.D., director of the department of nutrition at State University of Iowa Hospitals, and Joyce Anne Foss, chief administrative dietitian, West Virginia University Hospitals.

Name New Officers

Edith A. Jones, chief of the nutrition department, National Institutes of Health, Bethesda, Md., was named president-elect of the association.

Adelia M. Beeuwkes, professor of public health nutrition, University of Michigan School of Public Health, took office as president during the meeting.

Other officers are: secretary, Virginia L. Harger, associate professor of institution management, Ohio State University, and treasurer, Mrs. Wintress Dalbey Murray, supervisor of nutrition services, Eastman Kodak Company, Rochester, N.Y. ■



Feeling thirsty? Think first of 7-Up. Seven-Up has a special knack for quenching (it stimulates the natural flow of moisture in the mouth). It has a distinctive fresh, clean taste. Pour a glass, and "fresh up" with 7-Up.

The pure ingredients of 7-Up are proudly stated on the bottle. Seven-Up contains carbonated water, sugar, citric acid, sodium citrate, flavor derived from lemon and lime oils.

The appeal of fruit — whether frozen or canned — can be as fresh as the ideas the dietitian can devise for using it

An open tart is perfect for showing off the color appeal of strawberries.

Add a Dash of Summer — With Fruit

BRIGHTLY colored fruit can put a reminder of summer into winter meals. Canned and frozen varieties make it easy, and inexpensive, for the dietitian to use fruit as an accompaniment to entrees, as an appetizer, and in salads, as well as for both simple and fancy desserts.

Grilled pineapple slices and peaches, for example, add visual as well as taste appeal to many meat entrees. For an extra fillip, especially attractive with roast turkey or chicken, brush canned peach halves with butter and broil until hot and slightly glazed. In each half, place several whole red maraschino cherries and a sprig of parsley. (See picture on page 132.)

With grilled ham steak or baked ham, try a slice of unpeeled orange, topped with a whole maraschino cherry, on each slice. Pork chops also take well to fruit flavors. They can be baked in a mixture of cherry juice, brown sugar, Worcestershire sauce, and lemon juice for a zesty accent. For serving, top each chop with a lemon slice and sliced maraschino cherries.

Cranberries in their many forms are, of course, an ever popular meat accompaniment, but they are equally good combined with other fruits, such

---

STRAWBERRY FILLING
(Yield: filling for 100 tarts)

Ingredient	Amount
Frozen strawberries	6¼ qts.
Cornstarch	3 cups
Sugar	2½ cups
or sugar substitute	5 tbsp. (120 tablets)
Lemon juice	¾ cup

Defrost strawberries. Combine half of strawberries with cornstarch and sugar (or substitute). Bring to boil and cook 1 minute until thickened. Add remaining strawberries and lemon juice. Blend well.

Fill tart shells with No. 16 scoop. Top with whipped cream if desired.

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Fruit makes an attractive garnish — and adds a bonus of flavor

Maraschino cherry molded salad uses gelatin and sour cream in an unusual and attractive fruit combination.

Glazed, broiled peach halves filled with maraschino cherries make a colorful accent for any poultry entree.

MARASCHINO CHERRY-PINEAPPLE SALAD
(Yield: 48 ½ cup servings)

Ingredient	Amount
Lime flavored gelatin	12 oz.
Lemon flavored gelatin	12 oz.
Boiling water	2 qts.
Crushed pineapple with juice (chilled)	No. 10 can
Sour cream	1½ qts.
Maraschino cherries (quartered)	2 cups

Stir gelatin into boiling water until completely dissolved. Cool but do not let congeal. Add pineapple, sour cream, and cherries to cooled gelatin. Stir until well blended. Place in oiled 12 by 20 inch pan. Refrigerate.

Garnish each serving with dressing and whole maraschino cherry.

as applesauce, diced apples, ground orange, and pineapple.

Fruit is a natural for the slightly heavier type of dessert that winter appetites so often dictate. Cobblers, pies, shortcakes and filled tarts, such as that shown on page 130, are all excellent choices that can be made with many different fruit fillings.

Fruited breads and muffins are an excellent choice for serving with a simple pudding or sauce dessert.

Fruit breads are also popular for a special breakfast treat, as are fruit and cereal combinations. Here is a suggestion which combines some elements of both. Top shredded wheat biscuits with sliced frozen peaches. Spoon over them a topping of melted butter, brown sugar, lemon juice, cinnamon and chopped walnuts. Broil until topping is hot and bubbly.

And don't overlook the special appeal that a hot cherry, pineapple, or apple sauce can give to breakfast meat dishes such as ham or sausage, or in place of sirup with pancakes or French toast.

There are enough delicious combinations of fruits and gelatins to serve a different salad every day. The fact that, in general, fresh fruits float in gelatin while others sink makes it possible to devise especially attractive layered combinations.

A few examples using both canned and fresh fruits that are available year round are: lemon gelatin with canned plums and fresh diced apples, lime gelatin with canned Royal Anne cherries and fresh grapefruit sections, orange gelatin with dried cooked prunes and fresh apples, cherry gelatin with canned apricots and bananas, and lime gelatin with canned pineapple and fresh orange sections.

Whether she uses fresh, frozen, canned or processed fruit, the dietitian can find many ways to add the fresh appeal of fruit to meals. ■

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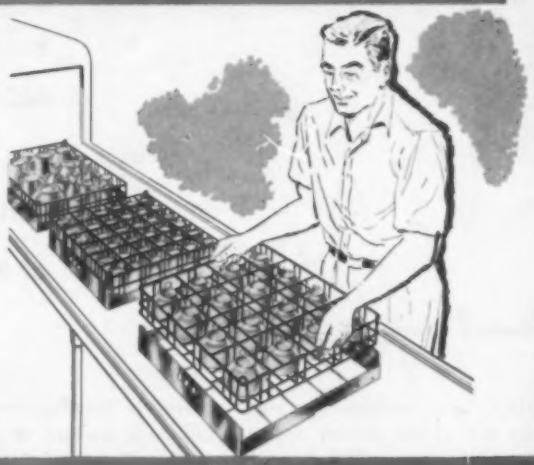
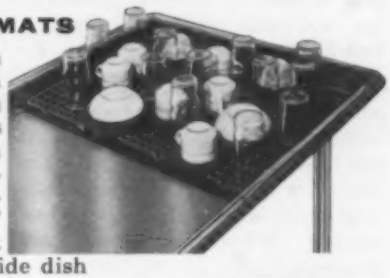
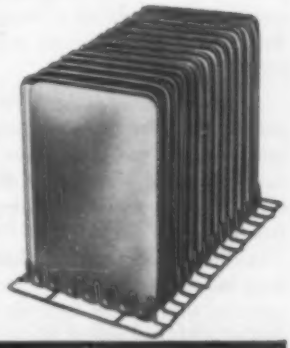


DISH TABLE MATS



Designed to cushion china at landing area of dish table. Green plastisol coated mats have one-half inch integral feet to permit thorough drainage. Available in 12″ and 18″ widths to fit 24″, 30″ or 36″ wide dish tables.

TRAY HOLDERS



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Why Raw Food Costs Are Hard To Isolate

Differences in what is charged to dietary costs and in how these costs are calculated make it difficult to compare food costs, this study of 54 New York State hospitals suggests

Mildred Sherwood

WHILE food budgets are used by half of the dietary departments, and 46 per cent of them do their own food accounting, few appear to have an accurate picture of raw food costs, a survey of 54 New York hospitals indicated.

For example, while 39 of the hospitals have pay cafeterias for personnel, 21 say they do no pricing at all and 11 others reported that they price "rarely" or yearly.

Although none of the hospitals had separate kitchens for patients and personnel, only seven have food credit or range sheets to record food used in the cafeteria and other nonpatient areas.

Actual tray count is used by 78 per cent of the hospitals answering this question to determine patient food costs, and 19 per cent used midnight census for their calculations. Bassinets are included in the tray count by 22 per cent, but half of the hospitals reported that the cost of supplies sent to the formula room is included in food costs.

About one-fifth of the departments do not include the cost of floor nourishments in their patient food costs. Nineteen per cent of the hospitals, however, indicated that any food sent to the floors for personnel is charged to patients.

Many hospitals reported charges made to "total dietary cost." To this indefinite account, 72 per cent of them charge "leftover" food, 37 per cent charge food sent to the floors for personnel, and 80 per cent charge special functions. Separate catering accounts have been set up by 20 per cent of the hospitals.

Personal observations by the dietitians on the survey committee of the Long Island Dietetic Association seem to indicate that the majority of hospitals calculate only a "served" food cost, *i.e.* salaries plus food and expense, divided by patient days, and that little attempt is made to separate the patients' raw food costs from other food costs.

Preliminary tabulations of the questionnaire used in the survey disclosed a variety of other information about dietary department practices in the hospitals.

Cycle menus are being used by more than half of the hospitals, with the commonest cycles covering from four to six weeks. Selective menus are used in 81 per cent of the hospitals and half use selective menus for both regular and therapeutic diets.

All but 15 of the hospitals serve dinner at noon, but five others offer dinner choices both noon and evening.

Steaks, roasts and chops are served regularly in 93 per cent of the hospitals, and 87 per cent also serve these items on request (22 per cent charge extra if the items are not on the original menu).

Meat portions ranged from 2 ounce to 9 ounce, but the commonest were: steaks, 4 ounce (43 per cent); chops, 4 ounce (39 per cent), and roasts, 3 ounce (39 per cent).

Meat grades served ranged from prime to commercial, but 76 per cent reported using prime or choice meats. Cuts of meats showed great variety: steaks, sirloin strip, 41 per cent; filet, 22 per cent; chops, loin, 61 per cent, and roasts, rib sirloin, 65 per cent, top round, 11 per cent.

Forty-two of the 54 hospitals have dietitians in charge of their food service. Ten have a steward, manager or food supervisor in charge of the dietary department, and two have registered nurses in charge. Bed capacities of the hospitals in the survey ranged from less than 50 to more than 500, but 56 per cent were in the 100 to 300 category.

Purpose of the survey, conducted by the food administration committee of the Long Island Dietetic Association, was to determine present food costing practices in voluntary hospitals.

One hundred eighty questionnaires were distributed to hospitals throughout New York State, and 34 per cent of them were filled out and returned. Because eight of the reporting hospitals were not voluntary, their answers were subtracted from the totals, and the figures based on the 54 voluntary hospitals that returned questionnaires. ■

The author is director of the dietary department, Community Hospital at Glen Cove, Glen Cove, N. Y.

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The Reading Hospital, Reading, Pa., started using Libbey Restraware on patient trays about two years ago. They were so pleased with the service that Restraware is now used throughout the hospital. And most important, Willis J. Haas, administrative assistant, reports that *dinnerware replacement costs have been reduced 54%.*

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Modern Food Management

These Reference Books Should Be on Food Service Department Shelf

By Jane Hartman

EVERY food service department needs a practical bookshelf of reference materials. Recently, several excellent publications have appeared that can be added to the reference collection.

Jane Hartman

A basic guide on the principles of food preparation is "Food for Fifty," 4th edition, John Wiley & Sons, Inc., 440 Park Avenue South, New York 16. This contains about 350 basic recipes. While the book is designed as a text for beginning students, it is a ready reference for anyone responsible for planning, purchasing, preparing or serving food in quantity.

Dietitians, food managers, engineers and architects will welcome "Food Service Planning: Layout and Equipment" by Lendal H. Kotschevar and Margaret E. Terrell, John Wiley & Sons, Inc., 440 Park Avenue South, New York ($10.75). The authors have applied principles of layout engineering to food service planning to demonstrate ways of decreasing operating costs while increasing efficiency. The book is divided into three sections: planning, layout planning, and selection of physical facilities and equipment. At the end of each chapter there are selected references. Illustrations, charts and diagrams are included.

From the U.S. Public Health Service, Division of Hospital and Medical Facilities, comes the new "Hospital Equipment Planning Guide." This publication is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. ($0.35). Suggested equipment and supply lists for 50, 100, and 200 bed general hospitals are presented as a guide for planners. Equipment is grouped under departmental headings; equipment for centralized tray service is divided into sections covering receiving entrance, janitor's closet, storage, kitchen, tray setup, serving and distribution, potwashing, office, dishwashing, ice manufacture, and cafeteria.

For small hospitals, "Meal Planning and Food Buying For Small Hospitals and Nursing Homes" by Kathleen Stitt and E. Neige Todhunter will be an invaluable guide to better food service. This booklet is obtainable from School of Home Economics, University of Alabama, Box 1405, University, Ala. ($1). Much of the material is in outline form and easily readable. Subjects covered include the place of food service in the hospital program, menu planning, modifying the normal diet, purchasing, storage, and sanitation, as well as additional sources of information.

Many other good textbooks and guides are, of course, available. The important point is that dietetic information is continually expanding and improving. Keep your reference shelf both complete and current! ■

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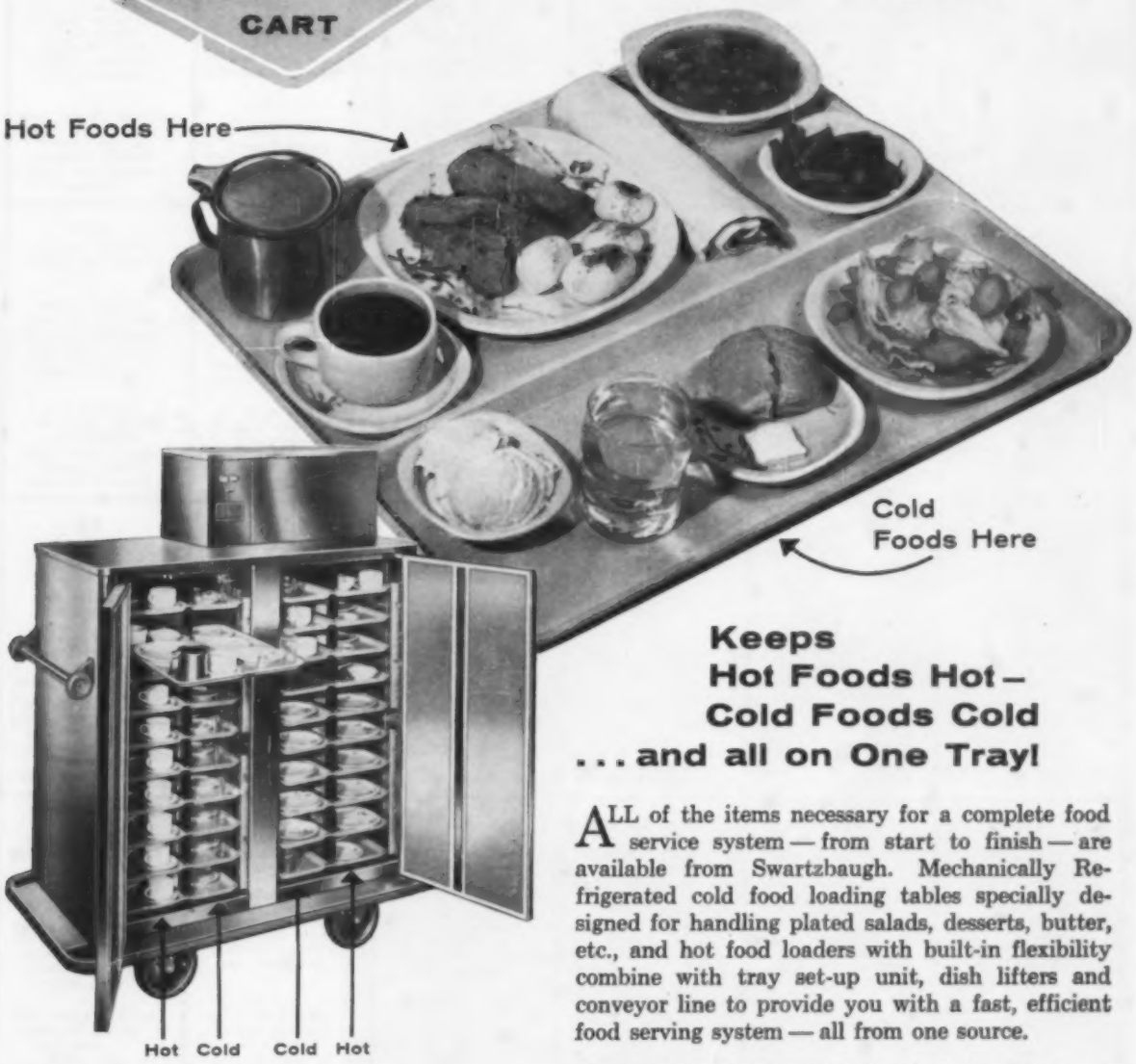

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The Swartzbaugh UNITRAY cart is designed to be coordinated with other Swartzbaugh food service units, if desired, to give you a centralized food service system — with complete kitchen control.

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Menus for January 1962

Florence L. Andrews
Chief Dietitian
San Antonio Community Hospital
Upland, Calif.

1 Cranberry Juice Bacon Omelet • Minted Fruit Cup Roast Beef au Jus Yorkshire Pudding Buttered Cauliflower Green Salad, Tomato Sherry Almond Floating Island • Cream of Mushroom Soup Club Sandwich Ripe Olives, Stuffed Celery Hearts Steamed Fig Pudding, Lemon Sauce	**2** Fresh Sliced Oranges Bacon, Scrambled Eggs • Consomme Madrilene Baked Virginia Ham Scalloped Potatoes Chopped Spinach Perfection Salad Sherbet Parfait • Oxtail Soup Asparagus on Toast Baked Sweet Potato String Beans Fresh Fruit Salad Brownie	**3** Pineapple-Grapefruit Juice Chipped Beef on Toast • English Beef Broth Smothered Chicken Farina Dumplings Stewed Tomatoes, Okra Carrot-Raisin Salad Jelly Roll • Chicken Gumbo Soup Grilled Salisbury Steak Baked Mashed Potato Peas With Chervil Lettuce, Chiffonade Dressing Baked Pears	**4** Stewed Prunes Baked Eggs, Sausage • Cream of Spinach Soup Roast Rack of Lamb Pan Browned Potatoes Braised Celery Pickled Beet Salad Pineapple Cubes • Broiled Sweetbreads and Mushrooms on Toast Baked Banana Squash Green Pepper-Paprika Cottage Cheese Salad Spice Cake, Mocha Frosting	**5** Fresh Orange Slices Poached Eggs on Toast • Clam Chowder Grilled Swordfish Stuffed Baked Potato Sauteed Parsnips Red and White Coleslaw Strawberry-Rhubarb Whip • Oyster Stew Tuna-Olive Tarts Lima Beans Broiled Tomato Tossed Green Salad, French Dressing Tropical Ambrosia	**6** Applesauce and Raisins French Toast, Sirup • Braised Sirloin Tips With Water Chestnuts Brown Rice Mashed Rutabaga Sweet-Sour Lettuce Boysenberry Pie • Chicken Noodle Soup Scalloped Ham, Potato, and Egg Casserole Buttered Asparagus Molded Fruit Salad Custard
7 Half Grapefruit Coffee Cake, Bacon • Cider Cocktail, Canapes Roast Duckling Whipped Potatoes Baked Zucchini Polonaise Avocado Salad Ice Cream, Cherry Sauce • Tomato Bouillon Cheese Souffle Creole Green Beans Mixed Green Salad, Russian Dressing Green Grape-Banana Cup	**8** Banana With Cream Miniature Doughnuts • Split Pea Soup Ham Loaf Potatoes au Gratin Brussels Sprouts Waldorf Pomegranate Salad Apricot Gooey Cake • Bouillon Open Steak Sandwich Hash Brown Potatoes Butter Beans Tomato-Cucumber Salad Royal Anne Cherries	**9** Fresh Orange Juice Scrambled Eggs, Bacon • Vegetable Soup Veal Stroganoff Buttered Noodles Harvard Beets Romaine Salad Prune Whip • Chicken Consomme Broiled Lamb Chop Parsley Whipped Potatoes Baked Hubbard Squash Persimmon Salad Boston Cream Pie	**10** Stewed Rhubarb Philadelphia Scrapple • Crab Meat Cocktail Braised Tenderloin Baked Potato Frosted Peas Mixed Green Salad, Club Dressing Cherry Cobbler • Scotch Barley Broth Eggs Benedictine Buttered Lima Beans Molded Cranberry Salad Apple Tapioca Pudding	**11** Blended Fruit Nectar Soft Cooked Eggs • Grape Juice Stuffed Baked Pork Chop Mashed Sweet Potatoes Sauerkraut Lettuce Hearts, Chiffonade Dressing Banana-Orange Custard • Beef Broth Chicken Rice Croquettes Glazed Carrots Hearts of Artichokes, French Dressing Whipped Fruit Gelatin	**12** Stewed Apricots French Toast, Sirup • Vegetable Potage Baked Salmon Steaks Potato Balls Parisienne Broccoli Almondine Tomato-Avocado Salad Chocolate Eclair • Asparagus Soup Vegetable Chow Mein Chinese Noodles Tossed Salad, 1000 Island Dressing Preserved Kumquats
13 Grapefruit Sections Ham Omelet • Chicken Noodle Soup Pot Roast Beef Mashed Potato Creole Eggplant Ginger Ale Salad Apple Pie With Cheese • Lentil Soup Braised Chicken Livers and Mushrooms on Toast Baked Potato Spinach Timbales Carrot and Celery Sticks Tropical Compote	**14** Frozen Melon Balls Dollar Pancakes, Sirup • Shrimp Cocktail Fried Chicken Rice Pilaf Parsley Buttered Parsnips Olives, Celery Hearts Rainbow Parfait, Angel Food Cake • Italian Minestrone Creamed Ham and Peas in Patty Shells Baked Sweet Potato Frozen Fruit Salad Cinnamon Coffee Bars	**15** Fresh Orange Juice Shirred Eggs • Tomato-Clam Juice Roast Leg of Lamb Whipped Potatoes Broccoli Polonaise Blush Pear Salad Caramel Custard • Cream of Mushroom Soup Tamale Pie French Style Green Beans Citrus Fruit Salad Raisin Pudding, Foamy Sauce	**16** Mixed Stewed Fruits Bacon Omelet • Beef Broth Liver and Bacon Scalloped Potatoes Buttered Whole Carrots Tomato Aspic Salad Lime Chiffon Pie • Vegetable Soup Breast of Chicken Supreme Asparagus Tips Green Salad, Chiffonade Dressing Purple Plums	**17** Tomato Juice Chipped Beef on Rusk • Lentil Soup Swiss Steak Parsley Potato Cakes Spiced Red Cabbage Cottage Cheese Salad Fresh Fruit Cup Pound Cake • Chicken Noodle Soup Glazed Ham Loaves Corn Pudding Buttered Green Peas Grape Waldorf Salad Cranberry Sherbet	**18** Fresh Tangerines Soft Cooked Eggs • Pepper Pot Soup Baked Veal Birds, Thyme Dressing Mashed Potatoes Creamed Onions Persimmon Salad Hot Fruit Cobbler, Cream • Essence of Celery Soup Hot Chicken Salad Watermelon Pickles, Radish Roses Royal Anne Cherries
19 Fruit Nectar Hot Cinnamon Rolls • Tomato Bouillon Filet of Sole French Fried Potatoes Spinach Souffle Green Pepper Coleslaw Raspberry Bavarian Cream • Clam Bisque Curried Shrimp and Rice Fried Eggplant Carrot Date Salad Nectarines	**20** Fresh Orange Slices Waffles, Sausage Links • Consomme Julienne Individual Meat Pie, Mashed Potato Topping Baked Banana Squash Avocado Fruit Bowl Mincemeat Roll, Lemon Sauce • Vegetable Chowder Tomato-Cheese Rabbit Baked Potato Chef's Salad Cream de Menthe Sherbet	**21** Half Grapefruit Fried Eggs, Ham • Marinated Herring Roast Turkey Rutabagas and Potatoes Stuffed Celery Zabaglioni on Lady Fingers • Cream of Potato Soup Fresh Fruit-Cottage Cheese Plate Assorted Sandwiches Pink Almond Parfait, Nabisco Wafers	**22** Tomato Juice Scrambled Eggs • Scotch Broth With Barley Corned Beef Brisket Parsley Buttered Potatoes Cabbage and Carrots Grapefruit-Avocado Salad Heavenly Rice • Philadelphia Pepperpot Tuna Fish Pie Beets and Greens Assorted Relish Plate Fresh Applesauce and Sugar Cookie	**23** Stewed Rhubarb Goldenrod Eggs • Turkey Noodle Soup Spiced Beef Pot Roast Raw Potato Pancake Piquant String Beans Molded Fruit Salad Lazy Daisy Cake • Lentil Soup Stuffed Acorn Squash Scalloped Potatoes Lettuce Hearts, Chiffonade Dressing Pumpkin Pudding	**24** Fresh Orange Juice Bacon, Soft Cooked Eggs • Beef Broth, Matzoth Balls Chicken Fricassee Buttered Lima Beans Scalloped Tomatoes and Celery With Oregano Mixed Green Salad, French Dressing Peach Melba • Cream of Tomato Soup Veal and Mushrooms on Brown Rice Chef's Salad Frosted Angel Cake
25 Sliced Banana Poached Eggs • Chopped Chicken Livers Roast Fresh Ham Whipped Potatoes Peas in Cream Orange-Sweet Onion Salad Apple Whip • Vegetable Soup Hot Roast Beef Sandwich Lyonnaise Potatoes Browned Parsnips Ginger Ale Salad Caramel Custard	**26** Grape Juice Fried Cornmeal Mush • Blended Vegetable Juice Mixed Sea Food Plate Scalloped Potatoes Brown Butter Kale Persimmon Salad Sherbet, Sunshine Cake • Cream of Celery Soup Codfish Cakes Baked Stuffed Potato Zucchini Creole Lettuce, Vinaigrette Dressing Raspberry Sundae	**27** Stewed Prunes French Toast, Sausage • Consomme Madrilene Stuffed Cabbage Rolls* Mashed Potatoes Julienne Carrots Sliced Cucumbers Lemon Meringue Pie • Chicken a la Reine Minute Steak Buttered Hominy Broccoli Polonaise Molded Vegetable Salad Baked Pears in Ginger	**28** Pineapple Juice Scrambled Eggs, Bacon • Broiled Grapefruit Baked Rock Cornish Hen Wild Rice Candied Sweet Potatoes Fresh Asparagus Tossed Green Salad Cherry Jubilee • Oyster Stew Assorted Cold Cuts Hot Potato Salad Herbed Tomato Slices, Lettuce Fresh Fruit Plate	**29** Fresh Grapes Creamed Eggs on Toast • Consomme Julienne Pepper Steak Riced Potatoes French Fried Eggplant Red Wine Slaw With Bacon Bits Burnt Sugar Cake • Cream of Tomato Soup Lamb Stew Cottage Cheese-Pear-Pomegranate Seed Salad Lemon Sponge	**30** Fresh Citrus Sections Shirred Eggs • Onion Soup Italian Spaghetti, Tiny Meat Balls Antipasto Spumoni • Mushroom Soup Hot Smoked Tongue Parsley Boiled Potato Buttered Peas Romaine-Avocado Salad, French Dressing Hot Blueberry Cobbler
31 Kadota Figs, Frizzled Chipped Beef, • Chicken Broth, Baked Short Ribs of Beef, Whipped Potato, Beets in Sour Cream, Spinach-Chopped Egg-Onion Salad, Snow Pudding • Mock Turtle Soup, Turkey a la King, French Style Green Beans, Molded Cinnamon Apple Sauce Salad, Date Nut Square. Ready-to-eat or cooked cereal served on all breakfast menus.					

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Compressed gas, air and vacuum systems are not difficult to maintain if the steps outlined here are followed regularly

How To Check Piped Service Systems

Christopher Montieth

MAINTAINING a compressed gas, air or vacuum system is neither complicated nor extremely time consuming; it can be done easily in most hospitals.

Although the high quality of piping equipment being manufactured today makes it unlikely that many opportunities exist for serious breakdown, any mechanical unit is liable to some sort of failure. The importance of piped services to a hospital makes it imperative that the engineering and maintenance staff set up a routine that will prevent failure.

Probably the most effective long-term method of minimizing any problems in the piping system lies in the original planning and choice of equipment that will go into the piping system.

Planning includes the proper layout and design of pipelines along with the proper layout and location of equipment. The equipment should be adequate to form the basis for the hospital's anticipated future needs. After the equipment has been selected and the design has been completed, proper installation is vital. Assembly of the pipelines, location of main shut-off valve, location of zoning valves, and installation of alarm systems to warn of failure are jobs that must be done correctly the first time.

The size of pipe used in a vacuum system can make the difference between an effective trouble-free service and one that requires excessive maintenance and is often not working. If an undersized vacuum line, for example, is installed in the hospital, matter that may be drawn into the line if the float shut-off valves do not work properly may cause the pipelines to become plugged with drainage matter. This presents a tremendous problem to the maintenance man because it is extremely difficult or impractical to get into the outlet station to remove the foreign matter. Often the outlet station has to be taken out of the wall to allow cleaning of the pipe. Not only does this make the outlet station inoperative, but removal of the outlet and pipe cleaning is a very expensive operation.

Recently, a proposed standard for vacuum systems in hospitals was written and submitted to the Compressed Gas Association for adoption.

The standard calls for a minimum vacuum of 12 inches of mercury at the outlet station furthest away from the vacuum pump, when the calculated demand for the hospital is drawn on the system. It is recommended that in the design of vacuum

(*Continued on Page* 144)

Mr. Montieth is chief engineer, Hackensack Hospital, Hackensack, N.J.

Photographs courtesy W. E. Doering, National Cylinder Gas, Division of Chemetron Corp., Chicago.

Secondary oxygen equipment should be checked at least monthly. Damage can be caused by improper use, such as when a nurse turns a flowmeter upside down while the humidifier is attached, causing water to run into flowmeter.

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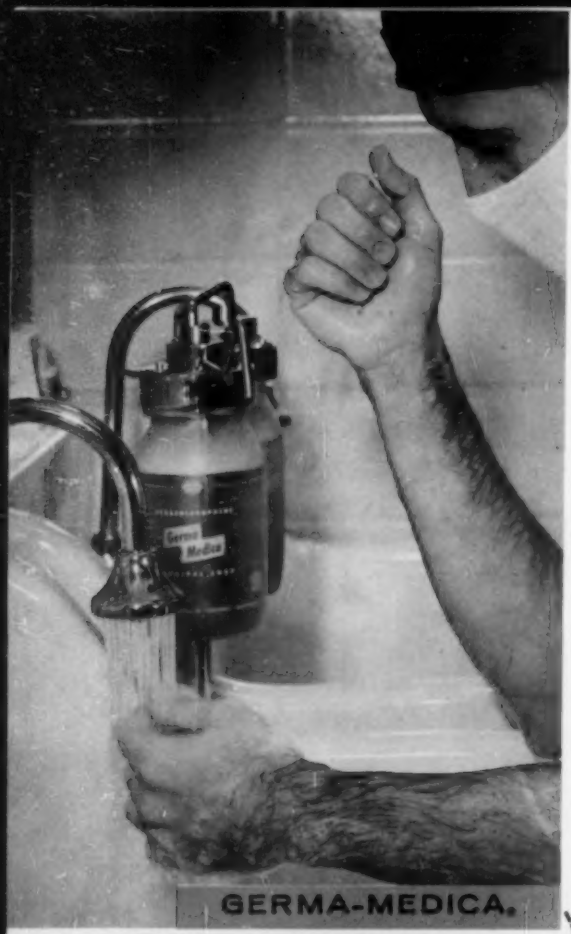

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How to prevent infection from originating in the hospital. That's the problem. Many hospitals are solving it by returning to old-fashioned attitudes toward cleanliness in every department combined with the use of modern, efficient aseptic products. And they are adopting the basic principles of a Patient-Safety Program to set up a common-sense plan-of-attack against resistant Staph. and all other infectious agents.

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- An intelligent Huntington representative to help you plan the program to meet your specific needs. Individual hospital aseptic problems differ because of variations in layout, in function and in use. The job of the Man behind the Huntington Drum is to select the right Huntington product or products for your hospital. He will show you how to efficiently and effectively use these products to destroy bacteria on all surfaces.
- An experienced Huntington representative whose advice and suggestions will greatly assist you while building and maintaining your Patient-Safety Program. His experience in the hospital aseptic control field averages 19 years.
- A company that completely backs up its men and products with research laboratories that place quality above all else. For over 41 years, these laboratories have been enforcing rigid control over the Huntington manufacturing processes.

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To protect control unit regulators, the engineer should crack the cylinder valve slowly before connecting a cylinder to a header. This will blow out any foreign matter that may have accumulated, and is trapped on the valve seats.

Simple Routine Inspections Often Detect Malfunctions

(*Continued From Page* 140)

systems, the pipeline be sized so that there is no more than a 4 inch drop in vacuum at the furthest outlet from the vacuum pump. Thus, the pump must be capable of maintaining a minimum of 16 inches of mercury vacuum.

Installation methods for a pipeline that will serve an oxygen system are extremely important. Such a pipeline must be free from any foreign matter, which is the cause of 90 per cent of the failures of outlet stations installed in hospitals today.

Foreign matter in the lines, when finally blown through, may be entrapped on the seat in the outlet station causing leaks to develop. It is also mandatory that silver solder connections be made, not soft solder. In one installation, for example, the oxygen pipelines were installed with soft solder, and it took approximately two years to clean out the lines and zoning valves, which had become completely plugged. In addition, pipelines must be completely free from oil because of certain hazards that could result from oil becoming trapped in the patient's lungs. Oil coming into contact with oxygen also presents a serious explosion hazard.

The control unit of the oxygen supply system should be checked daily to assure that the proper pressure is being supplied to the oxygen pipeline. This task requires little time because usually members of the engineer's staff are near the unit regularly.

In addition, at least once a month, the regulating valves should be checked for buildup in pressure. Such an increase will cause the regulators to "creep" and the safety relief valve to operate. The unit can be checked by reading the low pressure gauge normally furnished with each regulator and listening at the safety relief valve for escaping gas. The alarm system on the hospital line is another check on an increase in pressure. This increase in pressure is caused by faulty operation of the regulators in the control unit.

The alarm systems require periodic checking for proper operation. For example, the manifold alarm system can be tested by closing the valve on the service side of the oxygen supply and allowing the reserve side to cut in. As soon as the reserve side cuts in, the alarm buzzer and light should be actuated. This check will not interrupt the supply of oxygen to the hospital. This test is also useful for replacing burned out light bulbs in the alarm system.

To check the low pressure alarm system, the engineer must close the main shut-off valve for a very short time. When the line pressure reaches approximately 40 p.s.i., the low pressure alarm system should be actuated. As soon as the low pressure alarm has gone into operation, the main valve should be opened immediately to return the line to full pressure. A high pressure alarm system is checked by increasing the pipeline pressure through the manifold regulator to above 60 p.s.i.g. At this point, the high pressure alarm should become actuated.

All oxygen manifold headers include check valves as required by the National Fire Protection Association. The check valve prevents the depletion of the complete supply of gas in a bank if an individual cylinder blows its safety valve. When cylinders are attached to a header, the cylinder valve must be cracked slowly to blow out any foreign matter or chips that have accumulated. This step is very important to protect the check valves and the control unit regulators, which would become damaged from foreign matter trapped on the valve seats. The ground around bulk installations must be kept free of any debris, weeds and other material that could cause trouble if ignited.

The engineer should check each station outlet in the hospital at least every six months. A leak can be detected readily by a soap solution. The adapter should be inserted into each station to check for leaks between the hose end of the adapter and the valve seat in the outlet station. By plugging in the adapter the engineer can also check on the locking mechanism.

Malfunctions of outlet stations are usually caused by foreign matter being blown through the lines. Other types of damage are also possible.

If valve seat damage has occurred, it is a simple matter to disassemble the primary assembly and remove and replace the damaged valve seat. All outlet stations contain a secondary check valve to prevent the escape of gas when the primary assembly is removed. The outlet station is back in operation as soon as the primary assembly has been replaced.

Adapters require constant checking for damage caused by dropping. In-

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spection can be either visual or by listening for the escape of gas when the adapter is plugged in. Often, a faulty adapter can damage the locking mechanism and make it impossible to hold the adapter in the outlet station.

On outlet stations that make use of a threaded connection to hold the adapter, there is the possibility of cross-threading which will ruin the outlet station. When cross-threading occurs, it is necessary to replace the damaged adapter and change the complete valve body assembly in the outlet station. Periodic checking will reveal which outlets have been damaged by a faulty adapter.

In older installations where needle valves are used, the packing in the needle valve may set and cause a leak between the packing gland and the needle valve body. As a result, outlets of this type should be checked carefully at least four times a year because a great volume of gas can be lost through leakage. If a leak exists, packing should be replaced with the proper material, which is available from the supplier.

Outlets in the operating room must be in working order all of the time. Normally the anesthesiologist is responsible for the O.R. outlet stations because of his familiarity with the system. However, he should be cautioned to report any malfunction immediately so that the hospital engineer can take remedial measures.

To check a flowmeter, insert it into the outlet station and attach a humidifier to the unit. With the needle valve on the flowmeter closed, bubbles should not appear in the water. Bubbles indicate that the needle valve in the flowmeter is faulty. A humidifier provides the perfect tester for a flowmeter. Use of soap and water on the outlet of the flowmeter is not a good test because too much time is required for a leak to show up.

Both the inlet and outlet of flowmeters should be checked for damage caused by dropping. There is a very good possibility of damage to threads and the seat on a flowmeter that has been dropped. Dropping may cause a leak between these connections and the adapter. The damage can be detected with a soap solution, or a leak can be heard when a badly damaged unit has been plugged into an outlet station. Although damage to threads is best revealed by "go" and "no-go" gauges, these instruments are usually not available, and visual inspection is normally sufficient for detecting thread damage.

The use of ordinary tap water in humidifiers and nebulizers may result in calcium and lime deposits in the restricted openings of nebulizers and those humidifiers that contain a porous metal insert. This situation can be minimized by using distilled water.

Frequent and adequate inspection of secondary oxygen equipment depends on the department responsible for its maintenance. If the equipment is the responsibility of an inhalation therapist, it should be checked in the inhalation therapy department.

Secondary equipment should be checked at least once a month. Often a nurse will turn a flowmeter upside down while the humidifier is still attached, and the water will run into the flowmeter. When the equipment is returned to the proper department,

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it should be checked for visible moisture trapped within the tube. Trapped water can be removed from the flowmeter by oil-free compressed air blown into the unit with the needle valve open to provide a clear exit.

In a preventive maintenance program on vacuum pumps and air compressors, it is vital to choose the proper grade of oil, depending on the type of unit used and ambient conditions. If a pump is subjected to high temperatures, it may be necessary to use a heavier weight oil.

At least once a week, the oil level of the crank case should be checked and oil replenished if necessary. Oil in a vacuum pump should be changed at least every two weeks, or as recommended by the manufacturer. Only the best oils are recommended.

Sleeve bearing motors should be oiled at least every three months with an oil of approximately the same viscosity of S.A.E. 10. Ball bearing motors should be repacked once a year using a grease of about the same consistency as or a little stiffer than petroleum jelly. The motor windings should be blown off with a jet of air at least four times a year to prevent any accumulation of foreign matter. An occasional revarnishing of the windings with special insulating varnish will prolong the life of a motor.

Proper attention should be given to V-belt drives. A belt that is too tight will overload the bearings, while too loose a belt will slip on the motor pulley and cause excessive heat and wear. V-belts should be checked for tension at least once every three months. If one belt on a multiple V-belt drive breaks or becomes worn, all the belts should be replaced at the same time.

It is important to open the receiver drain valves of vacuum pumps and air compressors at least once a week to remove accumulated condensation. A check of the vacuum switch setting is also important because the vibration of the unit may cause it to change.

The engineer should check the setting by watching the gauge installed on the vacuum pump or receiver and noting the readings at which the pump turns on and off. To obtain the reading at the "cut-in," it is necessary to activate an outlet station to reach the low setting of the vacuum switch, and at this point the pump should cut on automatically. The setting should be checked at least once every three months.

In addition, the alternator on a duplex vacuum pump system requires checking to ensure that the pumps are alternating properly. This check can be made in the same manner as the switch setting technic described previously. After the first pump unit has cut off and the system drops to its low setting, the second pump should cut in. When the demand on the line is beyond the capacity of one pump, the second pump should cut in to cause both units to carry the load. Improper operation of the alternator will cause excessive wear on one pump. A check on the operation of the alternator also will reveal automatically any blown fuses or possible disconnection of safety switches.

Vacuum pumps and air compressors often are ordered and shipped to the job site long before they are put into operation. Where the engineer anticipates such a delay he should inform the contractor so the units will be protected for the long storage period.

Constant vigilance is necessary to keep vacuum secondary equipment functioning properly. The responsible department should check it after each use. On suction model units, gas-tight seals are required between bottle and cap to prevent an undue strain on the vacuum system and excessive operation of the pumps. Glass suction bottles should be checked for cracks because of the possibility of an implosion when a cracked unit is applied to the vacuum system.

With low suction units — water-sealed bottle used with a water manometer — used extensively in pleural surgery, the engineer should check periodically for leaky seals. A seal that is not gas-tight or loss of vacuum from the central source could endanger the patient.

Most secondary suction equipment is furnished with a float shut-off valve that automatically cuts off the vacuum if the liquid level in the bottle rises too high. A faulty float assembly may cause the liquid to fill the bottle and enter the outlet station. As a result, the station may become clogged with drainage and require extensive work before it can be put back into use. After each use, the float should be checked by allowing the liquid level to rise in the bottle and noting that the valve cuts off the suction when the liquid lifts the float. ■

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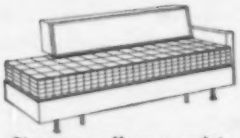

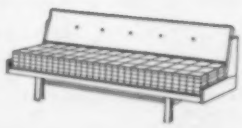

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How To Teach Cleaning Methods

The five-step teaching method reported here helps the hospital evaluate employe performance

Maude E. Chaney and Catherine M. Hawkins

ONE of the most important functions of the housekeeping department in an institution is to provide a program of correct teaching methods to assure cleanliness in all areas.

In Ohio, the state hospital association and Ohio State University have sponsored a series of workshops on "The Correct Teaching Methods" to provide housekeepers with the basic knowledge and background to conduct training programs for their own employes.

The purpose was to establish a correct and unified standard of teaching for executive housekeepers, assistants and supervisors.

This standard of teaching is known as the "five-step method," and has been extremely successful in industry. The steps are:

1. Outline the program of instruction
2. Prepare learners
3. Present the lesson
4. Try out
5. Check and follow-up

Each person attending the workshop actually participated not only as the teacher but also as a learner. Therefore he was taught the correct principles of teaching and, by placing himself in the position of the learner, absorbed additional knowledge that is the basis for improved teaching methods. As a learner, he realized the importance of correct teaching methods. The instructor, with the assistance of other participants in the class, gave constructive criticism as each demonstration was given. By illustrating and explaining each step, the learner could more easily absorb exactly what was expected of him to complete the work according to the standard set by the housekeeping department.

To employ proper teaching methods, three approaches to inservice training may be applied. The method most applicable to the department and institution should be selected.

1. On-the-job training. Training the employe while he or she is actually doing the work.
2. Classroom training. A specifically designated room used especially for teaching a class of from three to 10 employes.
3. Combination of classroom and on-the-job training.

In pursuing this program at the Ohio Tuberculosis Hospital, the first step was to call a departmental meeting of employes involved to explain what was going to be done and how the inservice training was to proceed. All work forms needed for inservice training were shown and explained to the employes. These forms included the skill inventory and classroom and individual employe forms. All questions were answered so there would be no doubt or suspicion as to what we were hoping to accomplish.

The next step was to determine the degree of retraining needed by our employes. To do this we:

1. Conducted a survey (skill inventory) throughout the entire hospital to evaluate general cleanliness and job performance. Two housekeepers were assigned to conduct this survey in order to rate all employes' performance equally.
2. Analyzed the skill inventory. This was beneficial in determining to what extent each employe needed retraining.
3. Prepared job breakdowns for each individual job, listing each principal step and the key points to each step.
4. Actually performed the job according to our breakdown to determine if changes were necessary for better teaching methods.
5. Prepared the learner by putting him at ease through a courteous and friendly approach. Placed him in the correct position, where demonstration could be observed, to receive instruction.
6. Presented the lesson by illustrating and telling, and stressed the key points very clearly.
7. Asked the learner to show and tell what he had observed and heard. If the learner made an error in telling or showing, this was corrected immediately. This would help him to remember exactly how and in what way he had made the error so that it would not be repeated.
8. Followed up. The learner was checked frequently. Questions were encouraged as to why the job was performed in a certain manner, and the employe was asked for his opinion on key points. At this time it was essential to know that the learner completely understood what had been taught. (*Cont. on Page* 152)

Miss Chaney is director of housekeeping, and Miss Hawkins is assistant director of housekeeping, Ohio Tuberculosis Hospital, Columbus.

The series of articles by Mildred L. Chase on Administrative Housekeeping for Institutions will be resumed next month.

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(*Continued From Page* 150)

9. Prepared individual and classroom records. Each employe was graded for attitude, aptitude and thoroughness. The following key was used.

1. Needs complete training.
2. Needs improvement training.
3. Performance satisfactory. Review periodically.

The forms used are permanent records which are kept on file in the housekeeping department office. They are valuable to the hospital and department for future reference.

The skill inventory form quickly provides a clear picture of the general cleanliness of the hospital. It is wise to make this survey at least every six months.

Employes' performance and progress are shown on the classroom and individual employe forms. Dates of training were recorded; also dates of the follow-ups were recorded if the employe met the job performance standard. If the job performance proved unsatisfactory, more retraining was needed and no dates were recorded until another follow-up proved satisfactory.

The accompanying box gives an example of a job breakdown. The importance of the job should always be explained to the employe before the instruction begins.

The information gathered from these workshops is extremely valuable to the housekeeping department,

Name of Hospital

Employe's Name:_____

INDIVIDUAL EMPLOYE RECORD

Code:
MPS - Meets Performance Standard

HOSPITAL JOB	MPS	HOSPITAL JOB	MPS
Cleaning wax applicator		Cleaning light fixtures	
Cleaning soft brushes		Cleaning radiator	
Cleaning chamois		Cleaning toilets	
Cleaning sponges		Vacuuming draperies	
Cleaning hair brushes		Vacuuming upholstery	
Cleaning vacuum cleaners ...		Vacuuming rugs	
Cleaning pails		Dry cleaning walls	
Cleaning buffing machine		Dry cleaning acoustical ceiling	
Cleaning scrubbing machine ..		Hand washing walls	
Cleaning wet mops		Cleaning wallpaper	
Cleaning hair push broom ...		Operating wall washing machine	
Brushing floor		Washing window shades	
Dry mopping floor		Turning window shades	
Damp sweeping floor		Servicing dispensers	
Wet mopping floor		Picking up and disposing of rubbish and garbage ..	
Hand scrubbing floor		Making a dormitory bed ...	
Operating scrubbing machine		Cleaning axle and caster	
Applying liquid wax		Machine darning for small holes or tears	
Operating buffing machine ..		Patching textiles	
Dusting furniture and equipment		Sewing on straps or tapes ...	
Dusting venetian blinds		Maintaining a sewing machine	
Cleaning brass			
Cleaning glazed surfaces ...			
Cleaning lavatory			

Individual employe record shows the specific housekeeping tasks for which the employe meets the hospital's performance standards. Classroom record, below left, is used to report dates of instruction and follow-ups. A simple key is used with skill inventory, right, to evaluate individual employe performance.

CLASSROOM RECORD

Code:
I - Instructed 4-Step Method
MPS - Meets Performance Standard

Name of Trainee

Housekeeping Job		John Smith	Mary Jones	Marie White	Dora Jones									
Cleaning shower	I	1/6	1/6											
	MPS	1/8												
Cleaning bathtub	I	11/17	11/17											
	MPS		11/18											
Cleaning bed	I													
	MPS													
Cleaning bedside cabinet	I													
	MPS													
Servicing towel cabinet	I													
	MPS													
Cleaning lavatory	I													
	MPS													

SKILL INVENTORY

Housekeeping Personnel

Hosp. Unit_____
Prepared by_____
Date_____

NAMES OF HOUSEKEEPING PERSONNEL

HOUSEKEEPING JOB	Mary Jones	Dora Jones	John Smith	Marie White								
Cleaning Bed	1	2	2	3								
Servicing Towel Cabinet	3	3	1	2								
Cleaning Shower	1	1	2	1								

Key: 1. Needs complete training
2. Needs improvement training
3. Performance satisfactory. Review periodically.

Easier-to-use master station and latest style telephone speed handling and simplify answering of patients' calls. Calls can be answered in succession or by selection. Nurse can contact any room to talk with patient or to monitor the room . . . can make calls to all rooms simultaneously . . . communicate with duty or utility rooms.

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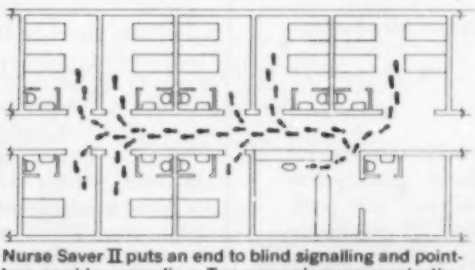

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How To Scrub a Wastebasket

The wastebasket is used only for trash. Metal and glass are deposited in separate containers. Maintaining a clean basket is very important to the health, welfare, and morale of the patient, employe and visitor. This prevents the spread of germs and contamination.

TOOLS NEEDED

Brush
Cleaning Cloths
Cleanser
Putty knife
Measuring Cup (1 oz.)
Germicidal Detergent

STEPS	KEY POINTS
1. Collect the wastebasket from the room.	Hold it away from the body. We have no knowledge of illness, and there is danger of contamination.
2. Empty the trash.	In the receptacle provided. Very quietly so as not to disturb the patients. Empty, holding away from receptacle so there will be no damage to the basket.
3. Take basket to the janitor's closet.	Do so quietly, and place the basket in the sink under the faucets.
4. Fill basket with small amount of hot water and germicidal detergent.	Measure germicidal detergent according to directions.
5. Thoroughly scrub the basket.	With the brush and scouring powder as needed. Pay particular attention to stubborn stains and accumulated dirt on inside and outside, top and bottom rims, crevices and on the underside of the basket where germs and bacteria can breed.
6. Rinse and dry thoroughly.	Rinse with hot water and dry with clean cloths. This prevents rusting of basket.
7. Check basket for leaks and for repainting.	Report to your supervisor if substitution needs to be made. Hold basket up to light to examine for leaks.
8. Clean the equipment used.	Hang up the brush. Discard cloths.
9. Return the basket to the room.	Place in correct position for neatness.

(*Continued From Page* 152)

and the hospital. A planned instruction program contributes to better and safer care of the patient, and it assures the patient of a clean and comfortable environment. The patient has a keen interest in what is being accomplished by the employes, which is good therapy because he is not constantly thinking of himself. The training given the employes has created job interest, self-development and improvement, better attitudes, pride and zeal to outdo one another in their performance.

Monthly departmental meetings are also beneficial. Group participation improves relationships not only among the employes, but between supervisors and employes.

Our hospital has and will continue to benefit to a great degree from this training because our standards are gradually upgraded, and we are receiving better performance from the employes as they understand and know their jobs better. Not only housekeeping, but other departments are benefiting through this planned inservice training. ■


AMERICA ON ITS KNEES

TODAY, all mankind stands in the presence of an awesome enemy. Our country faces its greatest peril. At this time of great need, free men throughout the world must turn wholeheartedly to God for new courage and strength, for we know that the final victory in the battle for peace rests in His hands.

Imperialistic communism, like the Biblical Goliath, menaces free men. That giant also swaggered, bullied and cowed the faint at heart. David came on the field of battle seemingly overwhelmed, yet supported by the power of God, he was victorious. The communist threat will in like manner be defeated if we confront the giant with the power of God.

With the sanctity gained from prayer, and the sanity from total preparedness, we will, like the shepherd boy, confront the enemy, and armed with the weapon of faith, we shall emerge victorious.

The prayer which appears on the facing page entitled "America On Its Knees" was written by Mr. Conrad N. Hilton. We believe this inspiring prayer expresses the fervent thoughts that must now be shared daily by all Americans and free men everywhere.

We are grateful to Mr. Hilton for his having written these inspiring words and for giving us permission to reprint them. We do so in the hope that this prayer will give those who read it renewed faith, courage, and strength.

HAROLD J. POND
Chairman of the Board
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OUR FATHER IN HEAVEN:

WE PRAY that YOU save us from *ourselves.*

The world that YOU have made for us, to live in peace,
we have made into an armed camp.
We live in fear of war to come.

We are afraid of "the terror that flies by
night, and the arrow that flies by day,
the pestilence that walks in darkness
and the destruction that wastes at noon-day."

We have turned from YOU to go our selfish way.
We have broken YOUR commandments
and denied YOUR truth. We have left YOUR altars
to serve the false gods of money and pleasure and power.

FORGIVE US AND HELP US

Now, darkness gathers around us and we are confused
in all our counsels. Losing faith in YOU,
we lose faith in ourselves.

Inspire us with wisdom, all of us of every color, race and creed,
to use our wealth, our strength to help our brother,
instead of destroying him.

Help us to do YOUR will as it is done in heaven
and to be worthy of YOUR promise of peace on earth.

Fill us with new faith, new strength and new courage,
that we may win the Battle for Peace.

Be swift to save us, *dear God,*
before the darkness falls ★ ☆ ★

*From the "Battle for Peace," an address by Conrad Hilton.

Presented as a public service by the Advance Floor Machine Company.

How Good Are the Programs in Hospital Administration?

(*Continued From Page* 92)

cle. We believe we have a profession, and we are acquiring all the accouterments, such as professional societies, annual congresses and journals. I hold that unless we are able to develop those "centers of creative thought" to which Robert Hutchins refers in "Higher Learning in America,"[11] we run the grave risk of losing what we have thus far gained and reverting to the status of a trade. A constantly developing curriculum, professionally capable teachers, alert and inquiring students are vital elements in such centers.

When we have gone far enough along this road we will have master's degree programs which will help to develop professional hospital administrators. We still will not have most of the elements of a doctoral program, as it is usually conceived in academic quarters. This is the point at which this article began. If there is substantial agreement with the analysis as it has been developed, then, for the present, doctoral programs in hospital administration must find some other base upon which to build than that provided by the master's degree offerings in this field.

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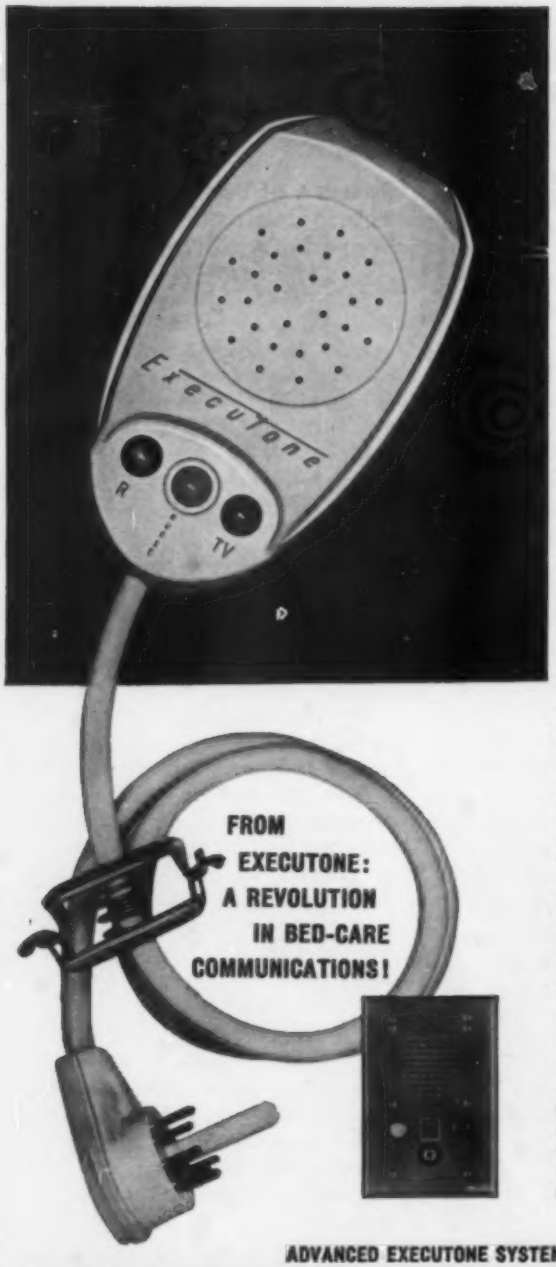

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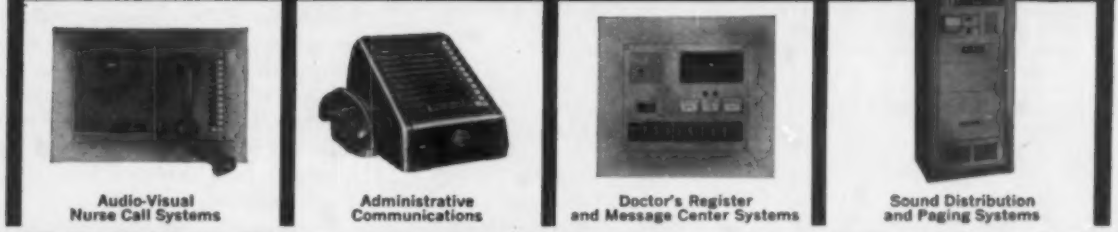

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The Modern Hospital News Digest

Economists See 1962 as Best Construction Year in History, Dodge Forecast Shows

NEW YORK.—The nation can expect its best construction year in history, according to F. W. Dodge Corporation's Construction Outlook for 1962.

Total building contracts in 1962, the report predicts, will amount to nearly $40 billion, a gain of 7 per cent over the estimated $37.3 billion for this year.

Hospital and institutional construction will taper off slightly, however, the report indicates. In 1961, this type of building accounted for a volume of 43 million square feet. Next year, according to the report, this classification will reach a volume of 42 million square feet, a decline of 2 per cent.

As a group, nonresidential building contracts will show a 4 per cent increase in 1962, the report forecasts. Residential building will also register its best year and total $17.5 billion in 1962, a 10 per cent increase over comparable estimates for 1961.

The report predicts a 6 per cent increase in heavy engineering contracts in 1962, with the total expected to reach $9.7 billion. Gains are anticipated in contracts for public works and for utilities.

In general, economists are "quite optimistic" about business prospects for next year, according to the report, which included a survey of 316 economists' opinions about 1962. Nearly all the economists agreed that spending for military goods and services will surge upward next year, thus providing a special stimulus to business activity. This activity, many of the economists thought, will lead the nation into a "garrison state" ready "to defend against instantaneous attack, and to retaliate immediately." ■

Estimated Physical Volume of Building

(48 states; figures in millions of sq. ft.)

Building Classification	Year 1961 Estimate*	Year 1962 Estimate	Percentage Change**
Commercial	286	286	0
Manufacturing	151	166	+10
Educational and Science	197	201	+2
Hospitals and Institutions	43	42	−2
Public	34	35	+3
Religious	52	53	+2
Social and Recreational	40	42	+5
Miscellaneous			
Nonresidential	29	29	0
Total			
Nonresidential	832	854	+3
Residential	1,346	1,452	+8
TOTAL BUILDING	2,178	2,306	+6
New Nonfarm Dwelling Unit Starts (Revised Census Bureau Basis)	1,300,000	1,400,000	+8

From F. W. Dodge Corporation's Construction Outlook for 1962.
**Eight months actual, last four months estimated.*
***Percentages rounded to nearest whole number.*

Beware of Bootleg Blood, Public Health Officials Warn New York Hospitals

NEW YORK. — Hospitals in New York and the northeastern states were warned last month against using blood or blood plasma from four commercial blood banks in the New York City area.

These blood banks now are being investigated by the U.S. Public Health Service and the National Institutes of Health.

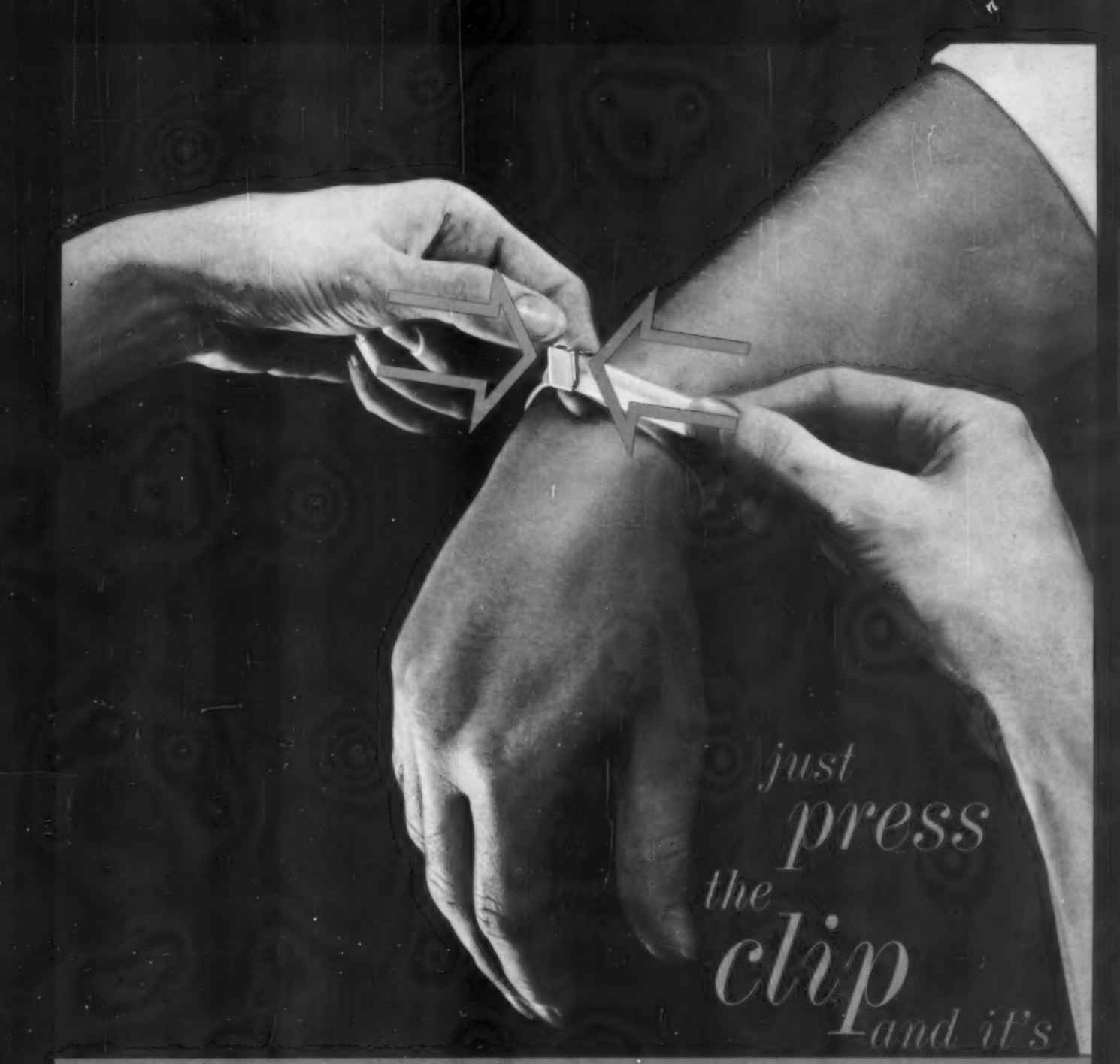
Blood sold by these banks was reported to be outdated and useless, the *New York Times* said, and the 22 city hospitals had been instructed by Dr. Ray E. Trussell, commissioner of hospitals, not to use it.

Dr. Trussell explained that only 5 or 6 per cent of transfusions given in municipal hospitals are supplied by licensed commercial blood banks. Most blood used in city hospitals is collected by their own blood banks or donated by the American Red Cross, whose supplies are not in question, he said. It was indicated, however, that the blood suppliers under investigation had sold blood and plasma to hospitals in a wide area of the Northeast.

Emphasizing that there was no evidence that any harm had resulted from use of blood purchased from the blood banks, Dr. Trussell pointed out, however, that blood that is more than 21 days old is not only useless but dangerous.

Investigation of the charges of violations referred by the Public Health Service has been started by the office of the U.S. attorney in Manhattan. The inquiry seeks to determine whether commercial operators have been diluting whole blood or selling outdated blood or plasma processed from outdated blood, the *Times* reported.

The blood banks under investigation are: Westchester Blood Service, Inc., and Metropolitan Blood Service, Inc., both of New Rochelle, N.Y.; Metropolitan Blood Service, West Orange, N.J., and Sidcaps Laboratories, Valley Stream, Long Island, N.Y.



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Kansas Hospitals Name A. Landon President-Elect

HUTCHINSON, KAN.—Arthur E. Landon, administrator of Asbury Hospital, Salina, was named president-elect of the Kansas Hospital Association at the 47th annual convention here last month. Mr. Landon will succeed Russell H. Miller, University Medical Center, Kansas City, the new president.

Walter V. Coburn, Bethany Hospital, Kansas City, was the retiring president.

With more than 300 administrators, trustees, auxiliary members, and other hospital workers attending, the convention heard detailed reports and discussion of Association activities, including new statewide programs in public education, hospital facilities planning, and uniform charging.

In its business session, the Association approved a dues increase to support the new programs.

Jack W. Owen, assistant director of the American Hospital Association, reported that 12 state hospital associations had adopted uniform charging practice methods.

The Association's public relations program, called "Contact," provides participating hospitals with manuals of instruction, suggestions and actual releases for newspaper and radio-TV station use. The program also includes training sessions for hospital news representatives, it was reported.

Other officers named by the Association were Bruce Bredeson, Ottawa, treasurer; Mr. Coburn, A.H.A. delegate, and Ivan D. Anderson, Emporia, alternate delegate.

W. C. Hansen Is Head of Idaho Hospital Group

BOISE, IDAHO. — Idaho Hospital Association members have elected W. C. Hansen as their new president. He is administrative assistant at St. Alphonsus Hospital, Boise.

Other officers elected are: president-elect, Raymond L. Tate, assistant administrator, Magic Valley Memorial Hospital, Twin Falls; secretary-treasurer, Leon C. Felder, administrator, Mary Secor Hospital, Emmett. New board members are: John B. Ernsdorff, business manager, St. Joseph's Hospital, Lewiston; Sister Jean Marie, administrator, Sacred Heart Hospital, Idaho Falls.

long-term care "noncriminal euthanasia."

Describing a warmer and more patient-concerned hospital of the future, he included "a review board to scrutinize all ritualistic practices periodically in a room scanned by television cameras and microphones and connected to a viewing room where any interested staff member or the public could see what was going on.

"This will make it possible to strike and organize picket lines any time there is a threat to change the human institution of the hospital into a factory for processing automatons," he concluded.

Dr. Robert F. Brown, director, The Doctors Hospital, Seattle, was installed as president succeeding William E. Murray, associate administrator, Providence Hospital, Seattle. Harry C. Wheeler, administrator, Deaconess Hospital, Spokane, was named president-elect.

The convention adopted a resolution asking planners of freeways to confer with hospitals early to ensure that plans for routes and access ramps would consider the demands of people regarding hospitals. One freeway, it was reported, is planned to pass so close to a Spokane hospital it would create a noise problem. A Seattle freeway is planned without regard for people wanting to reach a downtown area of six major hospitals and numerous medical office buildings.

A panel that included Frank S. Groner, immediate past president of American Hospital Association; Andrew Pattullo, director, division of hospitals, W. K. Kellogg Foundation, Battle Creek, Mich.; the state health director, the president of the state medical association, and a hospital architect agreed on the virtues of broad planning.

A consumer representative on the panel, Archie Rehn, a health and welfare trust fund administrator, asked: "How much planning for the future is available to us when we have a cost-conscious, irritated public demanding that hospital costs level off now, not tomorrow?"

Preside on Pacific Coast

R. F. Brown, M.D. (Washington)

S. O. Kivle (Oregon)

Oregon Speaker Suggests Some Ways Hospitals Can Solve Financial Problems

EUGENE, ORE. — "Let's get the hospitals' economic problems solved before we start on a grandiose federal hospital care plan," a doctor-congressman urged at the Oregon Association of Hospitals meeting here, October 22 to 24.

The speaker was the Hon. Edwin R. Durno, M.D., congressman from the fourth district. One way to help solve the economic crisis, Dr. Durno suggested, is "to get all units of government — national, state and local — to pay hospitals full costs for the care of indigent inpatients and outpatients." This will allow hospitals to stop taxing self-pay patients and third-party payers for the care of indigents, Dr. Durno said.

Another useful measure, Dr. Durno pointed out, would be a careful ex-

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Oklahoma Hospitals Line Up New Officers

New officers elected at the Oklahoma Hospital Association's recent convention are, left to right: president, Benny Carlisle, administrator, Community Hospital-Clinic, Elk City; president-elect, Richard C. Luttrell, administrator, Norman Municipal Hospital, Norman; vice president, James D. Harvey, administrator, Hillcrest Medical Center, Tulsa; treasurer, Joe R. Baker, administrator, Enid General Hospital, Enid; secretary, John J. Ramsey, administrator, Jackson County Memorial Hospital, Altus.

Many Hospital Rituals Are Outmoded, Doctor Tells State Meeting

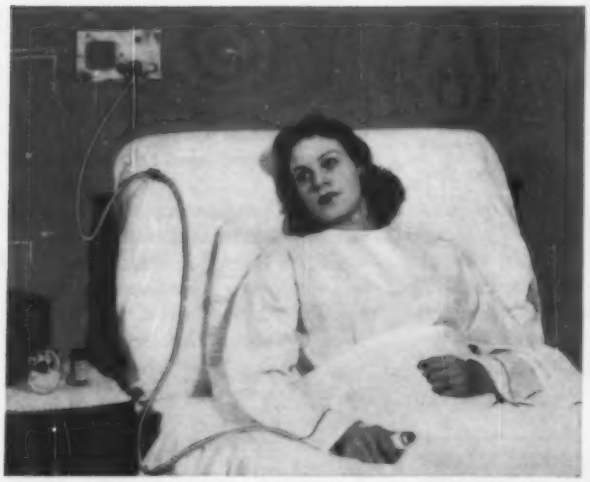
YAKIMA, WASH.—Some hospital rituals serve well, but many are continued only because nobody stops to think about them, Dr. Leon Lewis, Berkeley, Calif., internist and rehabilitation consultant, told the annual meeting of the Washington State Hospital Association here last month.

Among the rituals Dr. Lewis attacked were the cold welcome, the stripping routine, the bed, doctors' orders, visiting hours, silence because of noncommunication, the destructive ritual of long-term care, the ritual of departure, and the ritual of architecture and design.

He advocated that hospitals permit family members to stay with patients and even suggested that patients be allowed to have pets.

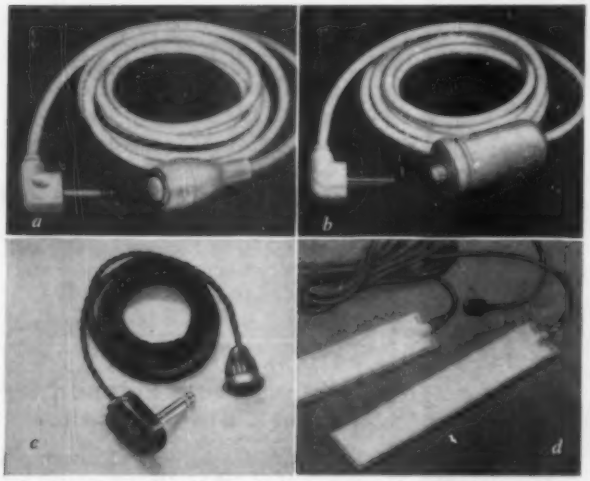
"From a health standpoint it is safer to pet a dog than shake hands with a friend," he observed.

He called the hospital bed "an extremely valuable modality, necessary, but like penicillin and digitalis, too much is poisonous." He termed most



▲ *The patient may talk to the nurse—even whisper—from any position in her bed.*

▲ *The nurse may talk to patients from her station, monitor their rooms, cancel their signals.*



▲ *Interchangeable cord sets for: a. normal patients; b. patients who cannot speak or hear; c. oxygen tents; d. immobile patients.*

▲ *Remote reply units enable the nurse to accept calls and talk to patients from locations away from her station.*

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Private Duty Fees Set at $20 a Shift in New Washington State Nurses Agreement

SEATTLE, WASH.—Private duty professional nursing fees in Washington State have been set at $20 for an eight-hour shift, beginning January 1. For the last two years the rate has been $18 on medical and surgical cases and $20 on specially diagnosed cases.

Because of difficulties in deciding and collecting the differential fee, the private duty nurses section of the Washington State Nurses Association voted to eliminate it, Clara Schnuriger, the chairman, noted.

The fee for multiple nursing of two patients in an emergency will be $17 for each patient. The minimum fee will be $5 and the fee for more than one hour and less than four will be $10. Time over eight hours in any one day will be one and one-half the regular fee.

The private duty section of the nurses association revised qualification standards to recommend that any nurse who has not been actively engaged in hospital bedside nursing for the past two years should be required to work in a hospital at least six months before doing private duty nursing.

Annual negotiating of agreements between hospitals and the Washington State Nurses Association for general duty nurses' minimum wages and benefits resulted in Seattle in a $20 monthly increase, making the new range $355 to $395; shift differentials of $25 for evening and $20 for night shifts; $10 premium for working in special service areas; $2 stand-by call pay for every eight-hour period and time and one-half for time worked on callback; two weeks vacation after four years, increasing in steps to three weeks after 13 years; seven paid holidays; 36 days accumulated sick leave; hospital-paid medical and hospital coverage.

The new agreement is for two years and covers 1846 registered nurses in 30 hospitals.

Outside the Seattle area the pattern of agreements was similar with the exception of $10 less provided as base pay.

Nursing Home Planned for Vacant Chicago Hospital

CHICAGO. — The 22 story St. Luke's Hospital building here will become a nursing home. The building has been vacant since 1959, when St. Luke's Hospital completed its 1956 merger with Presbyterian Hospital to form Presbyterian-St. Luke's Hospital by moving to a new location.

The nursing home, it was reported, will house a 450 bed project, called "Lake Vista," which will offer care for all types of geriatric disease, and will be staffed and equipped so that the main emphasis will be on rehabilitation of patients, rather than custodial care.

Patrick A. DeMoon, at present executive director of Franklin Boulevard Community Hospital and Central Community Hospital here, will be executive director of the nursing home, which has received F.H.A. insurance on a $2,031,300 loan. Architects for the remodeling of the building are Graham, Anderson, Probst and White. Completion is expected by early summer of 1962.

amination by medical staff members of their reasons for sending patients to a hospital. "Doctors must make a determined and continuing effort to reduce the incidence of hospital utilization per thousand population," he stated.

He also recommended that greater use be made of nursing home and long-term facilities and of diagnostic-preventive medicine clinics for patients who do not really belong in short-term hospitals.

A hopeful development in line with Dr. Durno's comments was the announcement by the Oregon State Industrial Accident Commission that it would henceforth pay hospitals on their regular billed rates.

Paul Hammer, administrator, Myrtle Creek Hospital, Myrtle Creek, was named president-elect of the association. Selmer O. Kivle, administrator, Good Shepherd Hospital, Hermiston, took office as president during the meeting, succeeding E. E. Bietz, administrator of Portland Sanitarium and Hospital.

Other association officers elected are: vice president, Sister Ernestine Marie, C.S.P., administrator, Providence Hospital, Portland; secretary-treasurer, P. D. Fleissner, administrator, McKenzie-Willamette Memorial Hospital, Springfield.

Indiana Hospital Group Holds Election of Officers

INDIANAPOLIS. — Richard W. Trenkner, administrator of Memorial Hospital, South Bend, Ind., has been elected president of the Indiana Hospital Association.

Other officers are as follows: president-elect, Jack A. L. Hahn, executive director, Methodist Hospital, Indianapolis; vice president, Sister Mary, administrator, St. John's Hickey Memorial Hospital, Anderson, Ind.; treasurer, Edmund J. Shea, administrator, Indiana University Medical Center, Indianapolis.

Three new trustees were also announced. They are: Robert E. Neff, hospital consultant, Indiana State Board of Health, Indianapolis (three years); Everett A. Johnson, administrator, Methodist Hospital, Gary, Ind. (three years); Arthur S. Malasto, administrator, Porter Memorial Hospital, Valparaiso, Ind. (one year).

Northwestern University Starts Program in Biomedical Engineering

EVANSTON, ILL. — Fourteen graduate students are enrolled in the new biomedical engineering program that is being offered for the first time at Northwestern University here, according to the Chicago Sun-Times.

These courses, university authorities explain, acknowledge that engineers and medical men are now working together to improve the practice of medicine through application of the latest electrical theory and electronic instrumentation.

Some of the developments faculty members hope will emerge from the cooperative efforts of engineers and physicians, the *Sun-Times* reports, are: new applications of computers to medicine; a method of modifying listening equipment for screening tape recordings of heartbeats so it will signal sounds indicating a defective heart, and automatic technics for telemetering the physical state and depth of anesthesia in patients during an operation.

Florida Hospital Association Hears Reports on Refugee Doctors, Discount Plan, Radiology

ORLANDO, FLA. — Middleton T. Mustian, administrator of the Alachua General Hospital, Gainesville, was named president-elect of the Florida Hospital Association at the annual meeting here last month.

More than 250 Florida hospital people, a record attendance, registered for the meeting.

In his annual report as president, Joseph F. McAloon, Memorial Hospital, Hollywood, said a committee of the association had rejected a proposal by state medical and radiology groups to divide hospital x-ray charges into two classifications — professional fees and "technical services."

Refusal to consider the proposal terminated discussions with the Florida medical association and radiology society, Mr. McAloon said.

The president also reported that the association had received "confusing and contradictory answers" to queries addressed to the American Hospital Association concerning the special problems of refugee Cuban physicians in Florida.

Mr. McAloon also announced that the Florida Blue Cross Plan had requested hospitals in the state to bill it at discount rates for services rendered patients over the age of 65 who would be enrolled in its proposed hospital coverage plan for the aged. The trustees of the state association, he reported, had considered the request carefully but felt that such an arrangement would not be fair to self-paying patients and other third party payers. The trustees, he said, then reaffirmed by unanimous vote the state association's position specifying that all third party payers must pay full cost for hospital care.

At a session featuring a panel of hospital trustees, John Ditzell, trustee of Winter Park Memorial Hospital, Winter Park, said that adequate, competitive salaries for hospital employes are essential to efficient operation. Frank Sullivan, president of Wuesthoff Memorial Hospital, Rockledge, emphasized the importance of careful review of physicians' qualifications for appointment and privileges. "Trustees have no greater responsibility than that of guaranteeing the hospital's patients high standards of medical care," he said.

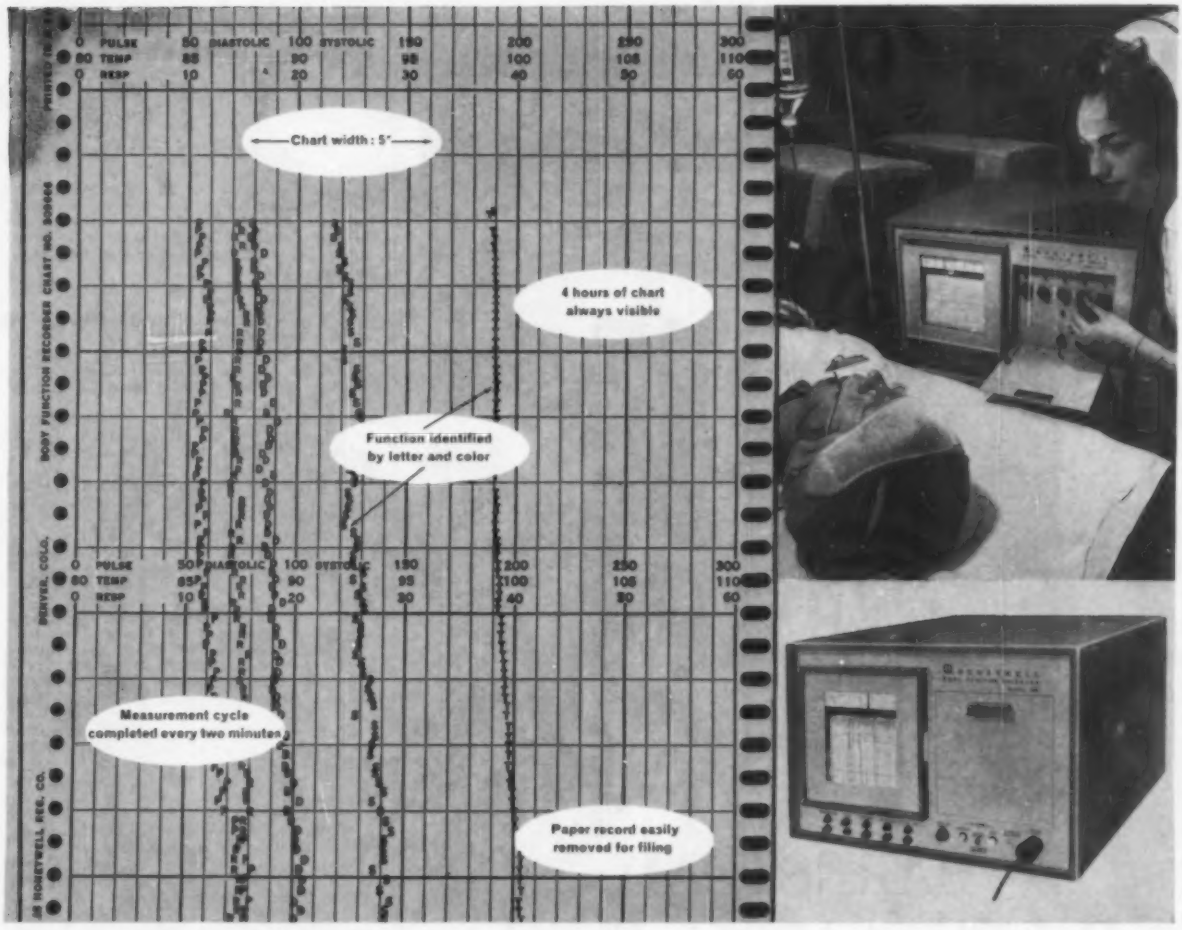
All members of the trustee panel agreed that government agencies should pay full cost for inpatient and outpatient care of indigents, including emergency room care.

In addition to Mr. Mustian, officers elected by the association were: secretary-treasurer, Richard E. Holladay, Memorial Hospital, Panama City; trustees, Sherwood D. Smith, Lakeland General Hospital, Lakeland, and Harry J. Underill, Brevard Hospital, Melbourne; A.H.A. delegate, Mr. McAloon, and alternate delegate, Don Laurent, Memorial Hospital, Sarasota.

Social Security Approach Endorsed by A.P.H.A.

DETROIT. — The American Public Health Association has endorsed the social security mechanism as a method of financing medical care for the aged.

The action was taken by the A.P.H.A.'s governing council at the association's annual meeting held here last month.



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(*Continued From Page 79*)

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COMING EVENTS

AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, Denver Hilton Hotel, Denver, Dec. 26-31.

1962

ALABAMA HOSPITAL ASSOCIATION, Admiral Semmes Hotel, Mobile, Jan. 17-19.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sheraton-Jefferson Hotel, St. Louis, Oct. 1-4.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS CONGRESS ON ADMINISTRATION, Morrison Hotel, Chicago, Feb. 1-3.

AMERICAN HOSPITAL ASSOCIATION, Midyear Meeting, A.H.A. Headquarters, Chicago, Jan. 31, Feb. 1; annual meeting, Chicago, Sept. 17-20.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Chicago, Feb. 26-Mar. 2.

ANNUAL MEETING OF BLUE CROSS ASSOCIATION MEMBERS AND THE ANNUAL MEETING OF THE NATIONAL ASSOCIATION OF BLUE SHIELD, Broadmoor Hotel, Colorado Springs, Colo., April 1-6.

ASSOCIATION OF WESTERN HOSPITALS, Memorial Coliseum, Portland, Ore., May 7-10.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Roanoke Hotel, Roanoke, Va., April 12, 13.

CATHOLIC HOSPITAL ASSOCIATION, Kiel Auditorium, St. Louis, May 21-24.

KENTUCKY HOSPITAL ASSOCIATION, Kentucky Hotel, Louisville, March 20-22.

LOUISIANA HOSPITAL ASSOCIATION, Capitol House Hotel, Baton Rouge, March 14-16.

MARYLAND-D.C.-DELAWARE HOSPITAL ASSOCIATION, Oct. 15-17.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 23-25.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 25-27.

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, Colony Beach Resort, Sarasota, Fla., Jan. 22-24.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler-Hilton Hotel, Boston, Mar. 26-28.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 23.

OHIO HOSPITAL ASSOCIATION, Toledo Sports Arena, Toledo, April 2-5.

SOUTH CAROLINA HOSPITAL ASSOCIATION, Wade Hampton Hotel, Columbia, Jan. 26.

SOUTHEASTERN HOSPITAL CONFERENCE, Municipal Auditorium, New Orleans, April 25-27.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 30-May 2.

WISCONSIN HOSPITAL ASSOCIATION, Schroeder Hotel, Milwaukee, Mar. 15, 16.

Columbia Alumni Elect Neil McGinniss Chairman

NEW YORK. — Neil McGinniss, director of Oakwood Hospital, Dearborn, Mich., was installed as chairman of the hospital administration section of the Columbia University alumni at their annual meeting in Atlantic City.

Chairman-elect for the section is David L. Everhart, assistant director of Henry Ford Hospital, Detroit. Secretary-treasurer is George Adams, assistant director of Methodist Hospital of Brooklyn, N.Y. Anthony J. De Luca, administrator of Griffin Hospital, Derby, Conn., was elected a member of the governing board of the association of the alumni of Columbia University School of Public Health and Administrative Medicine.

ABOUT PEOPLE

(*Continued From Page* 122)

Sister Miriam Dolores has become administrator of St. Alphonsus Hospital, Boise, Idaho, succeeding **Sister Alicia Marie,** who has been appointed administrator of St. Agnes Hospital, Fresno, Calif. At the same time, **Sister M. Laurencita** was appointed controller of St. Alphonsus Hospital, succeeding **Sister Alma Eugene,** who has been transferred to Holy Cross Hospital, San Fernando, Calif. **Gerald Culwell,** formerly with St. Agnes Hospital, was named credit manager at St. Alphonsus.

Joseph D. McGee has been appointed administrator of Central State Hospital, Lakeland, Ky. A graduate of Northwestern University's program in hospital administration (1957), Mr. McGee formerly served as assistant administrator, Saints Mary and Elizabeth Hospital, Louisville, Ky.

John F. Moulton has become director of Watts Hospital, Durham, N.C., succeeding **Sample B. Forbus.** Mr. Moulton received his M.S. in hospital administration from Columbia University (1947).

Charles Hudson has been named acting director of University Hospital, Jackson, Miss. Mr. Hudson will occupy the post of **Col. David B. Wilson, M.D.,** whose call to military service was announced in the November issue of The MODERN HOSPITAL.

Samuel Angel has been appointed administrator of the new 217 bed Howard Park General Hospital, Jamaica, N.Y. Mr. Angel, a graduate of St. Johns University, formerly served for five years at Madison Park Hospital of Adelphi College, Brooklyn, N.Y. He had served earlier as administrative controller of Barnert Memorial Hospital, Paterson, N.J., and Brooklyn Doctors Hospital, Brooklyn, N.Y.

Samuel Angel

George Heidkamp has been named acting administrator of MacNeal Memorial Hospital, Berwyn, Ill., succeeding the late **F. J. McCarthy.** Formerly, Mr. Heidkamp was assistant administrator at MacNeal.

James Goodrum has become administrator of Huntsville Memorial Hospital, Huntsville, Tex., succeeding **James H. Jackson,** who resigned. Mr. Goodrum formerly served as administrator of Madison County Hospital, Madisonville, Tex., for eight years. **Herbert E. Adams** has become administrator of Madison County Hospital, succeeding Mr. Goodrum.

Audrey M. Beloff, R.N., has accepted the position of administrator of St. Luke's Hospital, Middleboro, Mass. Formerly, Mrs. Beloff was administrator of Mary A. Alley Hospital, Marblehead, Mass.

Robert E. Harper Jr. has assumed the position of administrator at Boone County Hospital, Columbia, Mo. Formerly, he was administrator at Lincoln County Memorial Hospital, Troy, Mo.

Dr. James S. Glotfelty, medical director of the Veterans Administration Center, Los Angeles, has been temporarily appointed director of the Veterans Administration Hospital, Long Beach, Calif. He will serve as the replacement for **Dr. Michael L. Matte,** who has been called into military service.

J. D. Norris Jr. has been appointed administrator of Torbett Clinic and

Hospital, Marlin, Tex., succeeding **Eldon A. Easley,** who resigned to become administrator of Tyler County Hospital, Woodville, Tex. Mr. Easley succeeds **Mrs. Cecil Kent** at Tyler County Hospital.

Lawrence L. Smith has accepted the position of administrator of Chester Hospital, Chester, Pa., succeeding **Roger Wardlow.** Mr. Smith is a graduate of Northwestern University's program in hospital administration (1951).

Harry Wimple has become administrator of Memorial Hospital, Eagle Pass, Tex., succeeding **Allen Floyd,** who resigned.

Sister Mary Edward has been named business manager of St. Margaret's Hospital, Kansas City, Kan., succeeding **Sister Irmengarde.**

The Rev. Harold T. Grabau has become administrator in development at Grace Lutheran Hospital, San Antonio, Tex. Formerly, he was director of development in special gifts and estates at Texas Lutheran College, Seguin, Tex.

Tasker K. Robinette has been appointed administrator of the 50 bed Anacortes Hospital, Anacortes, Wash., currently under construction. He is a graduate of the hospital administration course at Washington University's school of medicine, St. Louis.

Harry V. Sanislo has been named administrator of Lakewood General Hospital, Tacoma, Wash., succeeding **Robert E. Heusers.** Mr. Sanislo is also administrator of Burien General Hospital, Seattle.

Ray E. Van Cleave has accepted the position of assistant director of hospitals, University of Texas medical branch hospitals, Galveston, Tex. Formerly, Mr. Van Cleave served as administrator of Hiawatha Community Hospital, Hiawatha, Kan. He received his master's degree in hospital administration from Baylor University, Waco, Tex.

Ray Van Cleave

James J. Herman has become assistant director for Presbyterian-St. Luke's Health Center, Chicago. Mr. Herman received his M.S. degree in hospital administration from Northwestern University.

Floyd D. Parrish has assumed the duties of assistant director at Greenwich Hospital, Greenwich, Conn. For-

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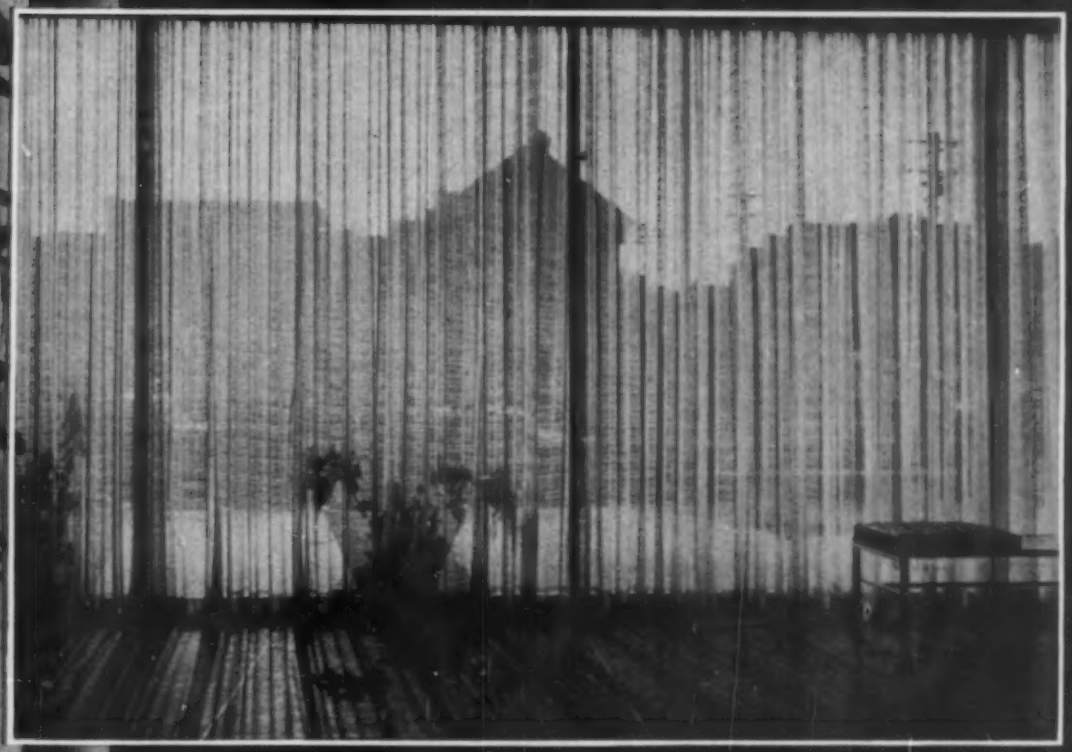

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merly he was special assistant to the commissioner of mental health, state of Connecticut, Yale University School of Medicine, New Haven, Conn.

Department Heads

Dr. Robert B. Lawson has been appointed chief of staff, Children's Memorial Hospital, Chicago, effective Feb. 1, 1962. He will succeed **Dr. John A. Bigler,** who plans to remain on the medical staff as consulting pediatrician. Dr. Lawson, who received his M.D. from Harvard University's medical school, is professor of pediatrics and chairman of that department at the University of Miami's school of medicine.

Clarence M. Bradley has been named methods improvement coordinator at Miami Valley Hospital, Dayton, Ohio, succeeding **Durward Holmes,** who resigned to enter private business.

Richard G. Tomaso has been appointed public relations director of St. Mary of Nazareth Hospital, Chicago. Formerly he worked with an advertising firm as a radio-television commercial producer and publicity and promotion representative.

Robert A. Hutchison has accepted the position of personnel director at St. Anthony de Padua Hospital, Chicago, succeeding **Sister M. Magna,** who has been appointed purchasing agent there. At the same time, it was announced that **Sister Agnes Clare** has been appointed chief accountant at the hospital.

Mrs. Joseph H. Ashton, R.N., has been named director of nursing services at Pontiac General Hospital, Pontiac, Mich.

Jack Linsley has become laundry manager of Baylor University Hospital, Dallas.

Mildred Pesek, R.N., has been appointed director of nursing service at Galveston County Memorial Hospital, LaMarque, Tex. At the same time, it was announced that **Shirley M. Robinson, R.M.R.L.,** has been named director of the medical record department, and **Joe B. Wilt** has been appointed director of supply.

Philip Gamache has assumed the position of purchasing agent for Manhattan Eye, Ear and Throat Hospital, New York. He succeeds **Anne Zazworsky,** who was purchasing agent at the hospital for the last 12 years. Mr. Gamache is an R.N., and holds a B.S. degree from Columbia University.

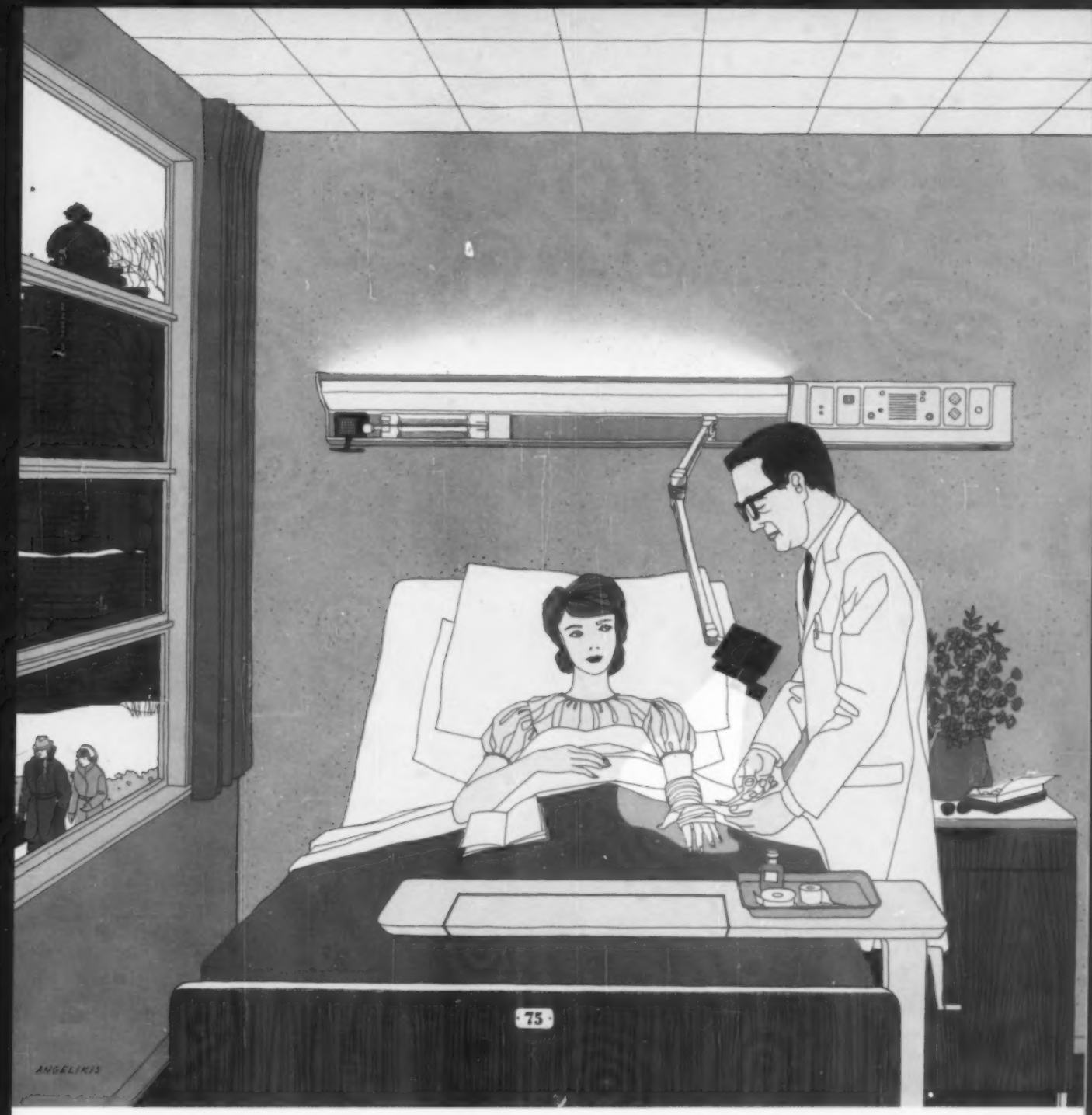
Philip Gamache

Miscellaneous

Dr. Earl C. Gluckman has been named a deputy director for professional services in the Veterans Administration's department of medicine and surgery, Washington, D.C., succeeding **Dr. Thomas M. Arnett,** who retired from government service. Dr. Gluckman, who received his M.D. from the University of Paris, France, formerly served as director of the Veterans Administration Hospital, Coral Gables, Fla.

Robert W. Murch has become consultant in hospital planning for Southern California, in the state of California department of public health's bureau of hospitals. A graduate of the University of California's course in hospital administration (1957), Mr. Murch was assistant administrator of Hollywood Presbyteri-

(*Continued on Page* 179)



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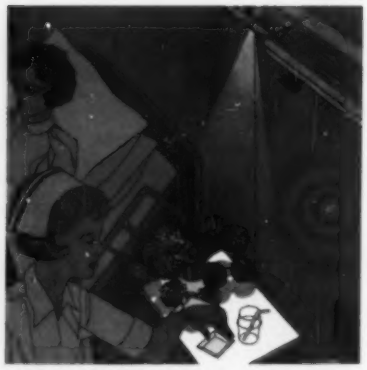

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(*Continued From Page* 176)

an Hospital, Los Angeles, for the last three years.

Doris Gleason, R.R.L., has resigned as executive director of the American Association of Medical Record Librarians, after 10 years in that capacity. **Mary J. Waterstraat,** former director of the school of medical record science at Grant Hospital, Chicago, has been appointed temporary executive director.

Deaths

Dr. Winford H. Smith, 84, died last month at Johns Hopkins Hospital, the institution he had served as director for a 35 year period spanning both world wars. A former president of the American Hospital Association (1916) and recipient of its distinguished service award (1943), Dr. Smith, as an administrator and consultant, received many awards and honors earned by his contributions to the health field and the army medical corps. Before his retirement from Johns Hopkins in 1946, he had helped plan and organize hospitals at the universities of Chicago and California; Yale, Vanderbilt and Duke universities; Cornell Medical Center, and Peking University Medical College Hospital in China. Earlier in his career, Dr. Smith had served as physician in charge of Kingston Avenue Contagious Hospital, New York; as superintendent of Hartford Hospital, Hartford, Conn., and as superintendent of Bellevue and Allied Hospitals (Fordham, Harlem and Gouverneur).

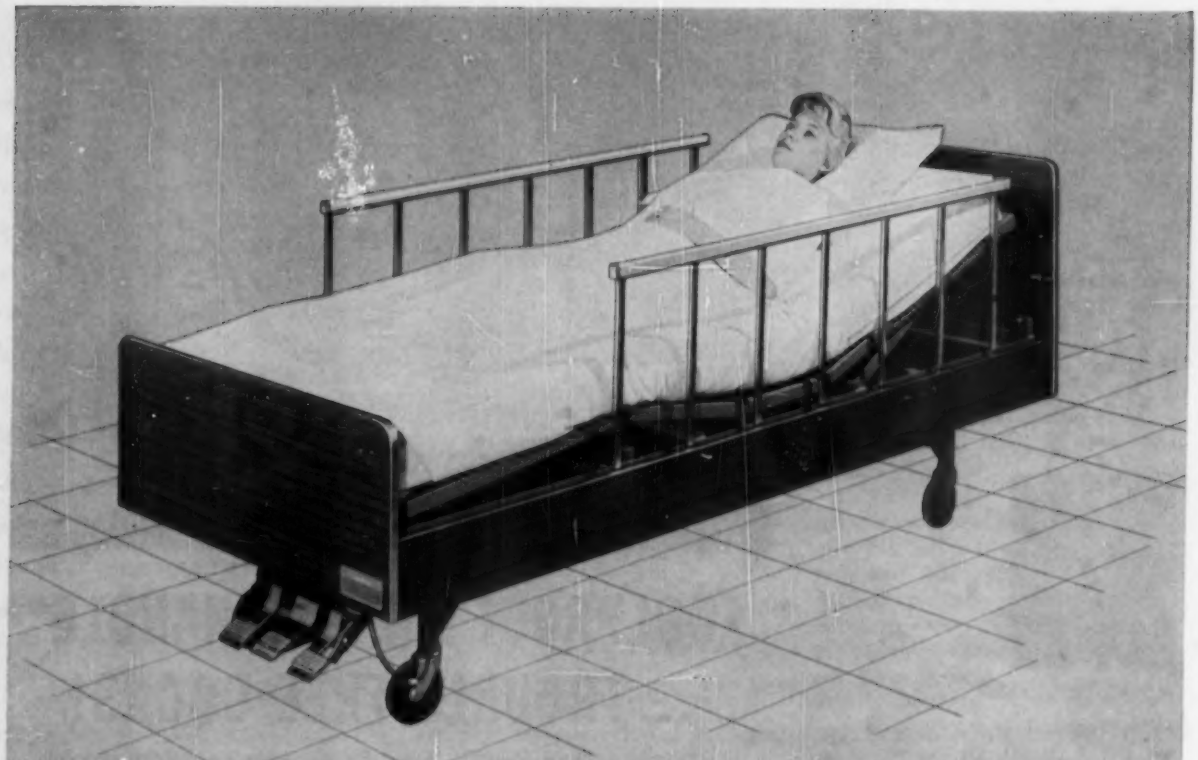
Dr. Smith

Sister Mary Regulata, administrator of St. Mary's Hospital, Philadelphia, from 1953 to August 1961, died at the hospital on September 16. She had been in hospital work for 50 years, also serving as administrator of St. Agnes Hospital, Philadelphia.

Sister Mary Magdalene, assistant administrator of St. John's Hospital, St. Louis, and former secretary and board member of the Hospital Association of Metropolitan St. Louis, died September 1 at St. John's.

John H. McCaa, business manager of Forrest General Hospital, Hattiesburg, Miss., died October 3. He was appointed business manager in July.

For additional information, use postcard facing back cover.



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POSITIONS WANTED

ADMINISTRATOR—Hospital; R.N., M.A.; mature, desires a position, ten years director of nurses, five year hospital administration; experienced in all phases of administration; available for interview. For resumé write MW 110, The MODERN HOSPITAL.

ADMINISTRATOR—Middle aged man with degree in Hospital Administration seeks challenging, new position in a middle sized hospital or in a smaller one with expansion prospects; has had 10 years experience including two construction programs; Member, A.C.H.A.; credentials upon request. Reply to MW 113, The MODERN HOSPITAL.

LIBRARIAN—Medical reference; experienced librarian; B.A., B.S.L.S.; wants position in or near Chicago. For resume write MW 112, The MODERN HOSPITAL.

MECHANICAL SUPERINTENDENT-EXECUTIVE HOUSEKEEPER; Building and grounds — graduate engineer; over 20 years heavy practical experience. Apply to MW 114, The MODERN HOSPITAL.

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ADMINISTRATOR—Desired for one of Chicago's finest nursing and convalescent homes; salary commensurate with experience. Send full resumé and requirements to MO 363, The MODERN HOSPITAL.

ANESTHETISTS—Nurse; 300-bed modern progressive hospital; excellent working conditions and benefits including shift differential bonus, 3 weeks vacation, liberal sick leave, retirement, 40 hour week including call hours; supervised by 3 M.D. anesthesiologists. Apply Personnel, NEW BRITAIN GENERAL HOSPITAL, New Britain, Connecticut.

ANESTHETIST—Nurse; to work with one other anesthetist; accredited, 68-bed general hospital. Apply Administrator, MARION MEMORIAL HOSPITAL, Marion, Illinois.

ANESTHETIST—Nurse; for 604-bed general hospital, no pediatric department, 40 hour week, plus overtime, salary open, generous employee benefits. Apply Personnel Office, AKRON CITY HOSPITAL, 525 East Market Street, Akron 9, Ohio.

ANESTHETIST—Nurse; newly activated Veterans Administration 1,000-bed, neuropsychiatric hospital, Brecksville, Ohio; liberal salary and fringe benefits, Cleveland — Akron area. Apply Personnel Officer, VA HOSPITAL, Brecksville, Ohio.

ANESTHETIST—Nurse; $500, new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital; college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, CHAMBERSBURG HOSPITAL, Chambersburg, Pennsylvania.

ANESTHETIST—Nurse; for 170-bed hospital; excellent personnel policies; 40 hour week; living accommodations in nurses' home if requested; collegetown. Apply: Richard E. Cummings, Administrator, J. C. BLAIR MEMORIAL HOSPITAL, Huntingdon, Pennsylvania.

ANESTHETIST—Nurse; for accredited 191-bed hospital expanding to 250-beds, with new surgical and anesthesia facilities; located 40 miles east of Pittsburgh, good personnel policies, paid vacation and sick leave, salary open depending on experience. Reply to: Administrator, LATROBE HOSPITAL, Latrobe, Pennsylvania.

CASEWORKER—For department of cardiology to work closely with physicians in both patient care and teaching; work is primarily centered in the cardiology and hypertension clinics of university hospital, but patient contact will also be a responsibility; weekly cardiology conferences provide the case worker the opportunity to express her views and to progress in professional education; salary begins at $4800 for MSW applicant. Contact: Mrs. G. Montgomery, Acting Director Department of Medical Social Service, FIRMIN DESLOGE HOSPITAL of SAINT LOUIS UNIVERSITY, Saint Louis 4, Missouri.

DIETITIAN—Opening available immediately; midwest college town; 75-bed hospital with 60-bed expansion in near future; salary open. Apply MO 345, THE MODERN HOSPITAL.

DIETITIAN—Therapeutic; for 550-bed tuberculosis hospital in eastern North Carolina; town of 30,000 population; A.D.A. preferred; salary range $4,632.00 to $5,904.00; Social Security and State Retirement benefits. Write to MO 364, The MODERN HOSPITAL.

DIETITIAN—Or food service manager; for 60-bed general hospital in west central Michigan; to be in charge of kitchen and food service; salary open. Contact Ralph Tarr, Administrator, GRAND HAVEN MUNICIPAL HOSPITAL, Grand Haven, Michigan.

DIETITIAN—Staff; excellent opportunity for therapeutic dietitian in 500-bed hospital, with intern resident program, school of nursing; salary open, commensurate with background; liberal benefit program. Apply Personnel Department, CHRIST HOSPITAL, 2139 Auburn Avenue, Cincinnati 19, Ohio.

DIETITIAN—Chief; A.D.A.; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open, 4 weeks vacation; social security; Blue Cross and Blue Shield available. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIANS—Positions open in two of the larger hospitals within a network of ten general hospital operating in the Appalachian coal mining region of Kentucky, Virginia, and West Virginia; ADA membership required, with experience in administration, teaching, and/or therapeutics; 40 hour week, 4 weeks paid vacation, 7 paid holidays; employee health program; social security, plus non-contributory retirement plan; salary open. Write or call collect: MINERS MEMORIAL HOSPITAL ASSOCIATION, Box #61, Williamson, West Virginia. Phone: BElmont 5-2424, Ext. 24.

DIRECTOR—Food services; director of food service department for VENTURA GENERAL HOSPITAL, pleasant Southern California coastal area; requires B.A. degree in foods, nutrition, or institutional management, internship in approved hospital, and 2 years experience as dietitian in charge of dietary unit or commercial food establishment; $490 per month. Apply Personnel Office, Court House, Ventura, California.

(Continued on page 182)

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POSITIONS OPEN

DIRECTOR OF NURSING—Overall responsibility; excellent educational director and nursing service assistant on the job; new 275-bed hospital and school of nursing buildings, air-conditioned; (See Modern Hospital Magazine June '55 and July '61.) Diploma school 152 capacity. Hal G. Perrin, Director, BISHOP CLARKSON MEMORIAL HOSPITAL, Omaha 5, Nebraska.

DIRECTOR OF NURSING—New 108-bed non-profit general hospital; no school of nursing; stable community 12,000 in northwestern Ohio; degree preferred; salary commensurate with qualifications. Apply Administrator, VAN WERT COUNTY HOSPITAL, Van Wert, Ohio.

INSTRUCTOR—In nursing care of children; diploma school; 300-bed hospital close to Baltimore and Washington; Bachelors degree preferred. Apply Director of Nursing, WASHINGTON COUNTY HOSPITAL, HAGERSTOWN, Maryland.

INSTRUCTOR—Medical and surgical nursing; Diploma School of Nursing in 150-bed general hospital in central Pennsylvania; B.S. in Nursing required; salary commensurate with experience; J.C.A.H. approved. Apply to Director of Nursing, CLEARFIELD HOSPITAL, Clearfield, Pennsylvania.

LIBRARIAN—Registered medical record; as chief of department; excellent salary; beautiful air conditioned department. For information contact Mr. F. W. Brown, Administrator, EDGEWATER HOSPITAL, 5700 North Ashland Avenue, Chicago 26, Illinois. Phone Up 8-6000.

LIBRARIAN—Medical records; registered preferred but not essential; ours is a 325-bed hospital 16 miles west of Chicago's loop; salary commensurate with qualifications and experience. Apply to: Personnel Director, MEMORIAL HOSPITAL, Elmhurst, Illinois.

LIBRARIANS—Registered medical record; Positions in three of ten general hospitals located in eastern Kentucky, southwestern Virginia, and southern West Virginia, operating on a regional pattern; two positions can be filled by a recent graduate, other position requires 5 years experience for consultative duty to community hospitals in region; salary $4,860 and $5,340 per annum; 40 hour week, 7 paid holidays, 4 weeks vacation, social security, employee health and increment program. Write: MINERS MEMORIAL HOSPITAL ASSOCIATION, Box #61, Williamson, West Virginia.

LIBRARIAN—Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week; salary open and commensurate with ability and experience. Send resume including experience, date available and salary desired to Miss G. A. Cooper Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

NURSES—General duty registered; for large general hospital in central California; in-service training program, excellent fringe benefits; shift differential — $376-433; water sports, hunting and fishing. Contact Personnel Director, Room 530, Courthouse, Stockton 2, California.

NURSES—General duty; for 320-bed JCAH accredited general hospital, only a few blocks from Lake Michigan beach and Lincoln Park; near Chicago Loop; school of nursing accredited by NLN; apartments available close to hospital; liberal personnel policies; openings on all shifts; must be eligible for Illinois registration. Write Director of Nursing, AUGUSTANA HOSPITAL, 411 W. Dickens Avenue, Chicago 14, Illinois.

NURSES—Registered; opening immediately; good working conditions, 40 hour week, above average pay in modern air-conditioned hospital. Write or call Wm. C. Brickley, Administrator, PLAINVILLE RURAL HOSPITAL, Plainville, Kansas.

NURSES—General staff; salary $4700 — $5300 depending on experience and qualifications; immediate openings in geriatrics hospital near Pontiac, Michigan; fine opportunities for advancement plus job security; excellent fringe benefits including: sick leave, retirement, insurance programs, vacations, etc. applicants must be registered with State of Michigan. Write Personnel Department. OAKLAND COUNTY OFFICE BUILDING, 1 Lafayette Street, Pontiac, Michigan.

REHABILITATION NURSING—Rehabilitation centers for children and adults; position for staff nurses; top salaries. For information write Director of Nurses, CROTCHED MOUNTAIN FOUNDATION, Greenfield, New Hampshire.

NURSES—Wanted; 24-bed hospital, Myrtle Creek, Oregon; basic scale, plus $25.00, plus living quarters to start. Write R. E. Williams, M.D., MYRTLE CREEK HOSPITAL.

(Continued on page 184)

classified advertising

POSITIONS OPEN

NURSES—Registered; labor room; general staff duty; all shifts; 3-11 and 11-7 supervisor. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

NURSES—Immediate opportunity available for both head nurses and administrative nurses in beautiful Ogden, Utah; The Thomas D. Dee Memorial Hospital has 240-beds and is a general hospital; graduate degrees and experience preferred and applicants must possess a minimum of a B.S. Degree or equivalent in terms of supervisory experience of applicant; progressive policies make this an exceptionally inviting area in which to practice. Make application or inquiry to Director of Personnel, THOMAS D. DEE MEMORIAL HOSPITAL, 2440 Harrison Boulevard, Ogden, Utah.

NURSES—Staff; 245-bed fully accredited general hospital; 40 hour week, 2 weeks vacation, 6 paid holidays, 12 days sick leave annually; starting rate $330; good recreational area. Apply Director of Nursing Service MEMORIAL HOSPITAL, Casper, Wyoming.

PHARMACIST—Large general teaching hospital; maintain rotating schedule with opportunity to work in all areas; 40 hour week, vacation holidays, sick leave, and other benefits. Contact: The Personnel Office, CLEVELAND METROPOLITAN GENERAL HOSPITAL, 3395 Scranton Road, Cleveland 9, Ohio.

TECHNOLOGIST—Or technician; medical; for laboratory work in 42-bed hospital of high medical standards (treats emotional disorders); salary commensurate with background and experience; very liberal fringe benefits; vacation; 36¼ hour week; no night or weekend calls; very attractive working conditions in modern air-conditioned laboratory; hospital located in Berkshire Hills, year-round resort area. Reply: Associate Medical Director, AUSTIN RIGGS CENTER, Stockbridge, Massachusetts.

TECHNOLOGIST — Medical; immediate opening for male or female, experienced, for 111-bed hospital in beautiful northern New Jersey, New York City; salary excellent. Apply CHILTON MEMORIAL HOSPITAL, Pompton Plains, New Jersey.

ADMINISTRATORS—(a) Dir med educ; 250-bd full accred gen; pref Bd or elig, int med; $15,000; MW (b) Dir med educ, 535-bd full accred gen; pref surg, Bd; exc financl oppor; univ city Mid-E. (c) Univ appntmnt to Chair of hsp adm; adm & dev prog leadg to MS; foreign English speag country; fine sal & consultg wk, lge city. (d) 450-bd full accred gen, med schl affil; reqs MS; attract

WOODWARD—*Continued*

sal; educ centr; S. (e) 300-bd full accred gen; w/MS; fine sal; twn 54,000 nr leadg MW culturl city. (f) MHA w/min 3 yrs exp; adm hsp inst w/2 units, 1500 empl; exc future & financl; E. (g) W/degree & extensive exp; new 200-bd gen; Calif. (h) 143-bd JCAH; reqs MS; $12-$15,000; lovely Mid-E twn. (i) Asst adm 425-bd full accred gen; reqs MS or equiv 5 yrs exper; fine oppor SW metropolis. (j) Asst adm, w/degree; 400-bd full accred hsp; sal arrngmnts open; MW. (k) Asst adm 200-bd full accred gen; reqs MS; exc sal & future; MW.

EXECUTIVE POSTS—(1) Dir of Admissions; dept hd status; 200-bd full accred gen gaining 100-bd unit nr future; S. Atlantic. (m) Dir of Psychology dept; very respons post; reqs Ph.D. & exper; $10,000; E. (n) Cl Mngr; new post; lge hlth plan; sal open; Calif. (o) Compt; pref CPA; new post; 700-bd full accred; univ centr; exc sal; Mid-S. (p) Pers dir, 270-bd full accred w/constructn prog underway to 400; exc sal; MW. (q) Purchasg agent, to intrp & dir centralized buyg sev lge units; heavy respons; SE.

NURSE ANESTHETISTS—(a) Vol gen hsp 75 bds; to $8400; small agricultural community, Pacific Northwest. (b) Approved 75-bed gen. hosp; minimum $7200; county seat community 7,000; southeast central. (c) Small gen hosp, affiliated clinic group; $9000, excellent fringe benefits; ideal southwest resort, outdoor sport area. (d) Join staff of 4, full time MD in busy dept, 200-bed fully approved gen. hosp; $7200 or more; MW. industrial city.

DIRECTOR OF NURSES—(a) Degree, experience required to head service, 300-bd voluntary gen hosp; $9,000; vicinity N. Y. City. (b) Small, lovely gen. hosp. $6600, full maintenance; southern cotton growing area; town 1500.(c) Full charge school, service, 200-bed gen. hosp, approved JCAH; vicinity $8000; New England Community 30,000. (d) Requires MA, several years experience to head school, service in 400-bed univ affiliated gen. hosp; $7200, full maintenance; large city; southeast central location.

FOOD SERVICE MANAGERS— (a) Degree preferred must be able organize, train employees in 300-bed gen. hosp; centralized service; residential suburb university medical center; SE. (b) To head department, small hosp opening mid-1962, will expand by additional 50 beds thereafter; city 40,000; Calif. (c) Full responsibility for very modern, complete food service; 200-bed approved gen hosp; residential suburb large city; E.

EXECUTIVE HOUSEKEEPERS—(a) Dynamic, capable individual to reorganize dept., small gen hosp; $6000; Chicago area. (b) Excellent opportunity for trained, experienced individual to head dept., fully approved 250-bed gen. hosp; large cattle, grain market, rail center; MW. (c) Approved gen hosp expanding from present 100 beds; $4200, excellent fringe benefits; fairly near San Francisco. (d) Prefer qualified male housekeeper to head dept., 150-bed approved gen. hosp; 30 in dept.; to $6000.

PHARMACISTS—(a) Chief; requires progressive, trained individual to head dept, 150-bed gen hosp; attractive college city 25,000; MW. (b) Supervise dept, gen hosp 350 beds; to $8400; Calif. coastal area. (c) Chief; 100-bed gen hosp opening late December, 1961; very modern, completely equipped; Texas community near popular resort area. (d) Chief: fairly new gen hosp 250 beds, fully approved; college city 100,000; SE.

ADMINISTRATORS—(a) Assistant to succeed Adm. 400-bed renowned M.W. hsp., $12-$20,000. (b) Adm. brand new 30-bed hsp. Calif; $7500 plus percentage gross income. (c) Asst. Dir., proficient hsp. acctg. large So.

MEDICAL BUREAU—*Continued*

hsp; $9000. (d) Adm. 150-300 bed hsp., suburban Chicago; aid new planning stages. (e) Adm. 300-bed Pacific Island hsp. housing, travel, moving provided.

ADMINISTRATIVE PERSONNEL—(f) Executive Secretary; nat'l. med. education society; $12-$14,000, M.W. (g) Bus. Mgr. 100-bed hsp. btfl. Chicago suburb, $8000. (h) Personnel Dir. 300-bed hsp. Phila. $7200 up. (i) Plt. Engineer — grounds mtce. $13,000 E.

DIRECTORS OF NURSING—(j) Direct service & school, Chicago area 300-beds; $10,000. (k) Nurse Educator, establish collegiate nurse program, $13,000, E. (1) Direct nursing 250-bed hsp. commute San Francisco, $10,000.

EXECUTIVE HOUSEKEEPERS—(m) 100-bed hsp. vicinity Chicago, $6000. (n) 350-bed hsp. San Francisco area $7-$7500. (o) 600-bed hsp. Texas, open.

ADMINISTRATIVE ASSISTANT—(a) 300-bed Michigan hospital; promotional opportunities. (b) Assistant superintendent, administrative services; 3000-bed eastern hospital. (c) 175-bed hospital, Pennsylvania. (d) 200-bed Iowa hospital.

ADMINISTRATOR—(a) Small proprietary hospital; west coast; ability to organize new hospital. (b) 60-bed Pennsylvania hospital. (c) 30-bed hospital, New York; building program planned. (d) R.N. Small private hospital, eastern Pennsylvania.

BUSINESS MANAGER—(a) 150-bed hospital, Ohio. (b) 125-bed northwestern hospital. (c) Large university city, west. 200-bed hospital. (d) Accountant; 100-bed new hospital, southwest. (e) Large New England hospital.

DIRECTORS OF NURSING—To $10,000.

CHIEF ENGINEER—(a) 500-bed hospital; south central state. (b) 200-bed Pennsylvania hospital.

DIRECTOR, Housekeeping Services—(a) (Male) 450 bed mid-western hospital. (b) 300-bed hospital, New York State. (c) 200-bed hospital, western city. (d) 250-bed eastern hospital.

(Continued on page 186)

TWO NEW WAYS TO GET MORE PHARMACY SPACE

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Memo to Hospital Pharmacists

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With the exclusive McKesson & Robbins COMPACT CABINET *you* control every inch of space. Movable and interchangeable trays adjust easily within the cabinet. Other trays fit on the inside of the wide swinging doors to put to work *all* the interior space which is wasted in ordinary cabinets of comparable size. This new flexibility more than triples the McKesson COMPACT CABINET capacity by meeting a wide range of storage space requirements without wasting an inch. Keeps your hospital supplies easy to see... easy to reach.

As illustrated above: McKesson COMPACT Storage CABINET, #100, is 35" wide, 16" deep, and 30¾" high. It comes with 20 adjustable steel trays with transparent plastic leading edges for greater visibility. This space-economizer can be used as a wall hanging unit or part of a complete installation. A floor standing combination consisting of two COMPACT CABINETS—one with a finished top, the other (#110) a center section, and a base (#120) with drawers 35" wide, 16" deep, and 22½" high—provides a space-saving 82¼" high unit.

MAGAZINE Space Saver DISPENSER

stores four times more in the same space!

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OPERATING ROOM SUPERVISOR AND CLINICAL INSTRUCTOR, O. R. Nursing (two positions)
For well-established voluntary 400-bed general hospital with two divisions, each with supervisory assistants and each with a caseload of about 450 operations a month. Seasoned staff of 44 including full-time Clinical Instructor in Operating Room Nursing. Three year diploma program with League accreditation, 100 students. Recovery rooms in each facility.

OPERATING ROOM SUPERVISORY position requires master's degree, five years of perience in operating room including teaching — supervisory responsibility or B.S. degree with equivalent experience and preferably a post graduate course in operating room nursing.

CLINICAL INSTRUCTOR, O.R. Nursing requires master's degree, five years of experience in operating room including teaching responsibility or B.S. degree in Nursing Education with experience in teaching operating room nursing.

Registration or eligibility for registration in New York State. Responsible to Director of Nursing and Administrator of Hospital. Well balanced personnel policies include four weeks' vacation, seven paid holidays, two — weeks' sick leave and Cumulative sick benefits, pension plan, social security, Blue Cross, group disability and life insurance coverage scaled to salary. Salary dependent upon educational qualifications and experience. Write Director of Nursing, THE ROCHESTER GENERAL HOSPITAL, Northside Division, Rochester 21, New York.

DIRECTOR OF BUREAU OF HOSPITAL REVIEW

New York State Department of Health Establish and carry out new State-wide program concerned with review of scope, quantity and quality of hospital care and direct studies and activities in the field of voluntary hospital insurance and medical economics.

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(Continued on page 188)

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- Every drawer in left oven column matches a patient tray in left cold column. The same is true with the right column of oven and tray sections.
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- Clean up time with Food-ala-Cart streamlined design is 25% faster because everything in the interior is quickly and easily removed and replaced.
- Food-ala-Cart offers nationwide service and distribution.
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If you are considering buying any type of hot and cold food carts, be sure you get the facts and prices on Nutting Food-ala-Cart before you decide. These facts will prove you can save money and serve better food with Food-ala-Cart. Write today for free literature and details.

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ST. FRANCIS HOSPITAL School of Anesthesia offers to graduates of accredited schools of nursing, an 18 months course in anesthesia. AANA accredited; approved under G.I. bill of Rights. Stipends offered throughout course. Classes begin April 1 and October 1, each year. Write Sister M. Catherine Ann, O.S.F., C.R.N.A. Director, School of Anesthesia, ST. FRANCIS HOSPITAL, Peoria 4, Ill.

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Edited by BESSIE COVERT

WHAT'S NEW

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Kalvaray One-Minute Dry Process Now Duplicates X-Ray Films

A duplicate x-ray negative or print can now be made from an original x-ray negative by a new dry process in the Kalvaray X-Ray Film Duplicator. Utilizing ultraviolet light for exposure and infra-red heat for development, without any liquids, solutions or other wet process, perfect diagnostic prints are produced in approximately sixty seconds, depending upon the size of the print, and at minimum cost. The reproductions have been declared legally acceptable for court appearance or other use.

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Contoured top sections, which are easily removed and replaced to fit the type of surgery to be performed, provide a unique feature of the Contour-Flex operating

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The contoured tops are fabricated of conductive plastic bonded by epoxy to aluminum, providing strength and durability with miniumum weight so that they are readily interchanged by one man. A mobile hanger holds the tops not in use, ready for quick change to meet the need for each patient. The sturdy base allows maximum foot room with minimum interference and is fully adjustable for height, tilt and other requirements. No restraints are required as the patient rests comfortably, without danger of rolling, and the anatomical design gives increased comfort and security, without pressure, under anesthesia. **Hausted Div., Simmons Co., Medina, Ohio.**

For more details circle #3 on mailing card.

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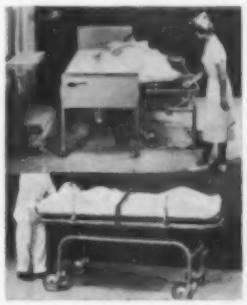
Containing no skin, bones or giblets, the Armour Cooked Boned Fowl Roll is precooked in a casing in natural juices to retain the rich flavor. Economical and convenient, it saves time, labor and storage space and permits exact portion control in preparing quantity chicken recipes. **Armour & Co., P.O. Box 9222, Chicago 90.**

For more details circle #4 on mailing card.

One Nurse Can Transfer Patient With Amsco Trancar

A new system for the transfer of critically ill and postoperative patients is offered with the Amsco Patient Tranfer System employing the newly developed Trancar. The enameled steel, four-wheeled car with movable Paraglas top permits one small nurse quickly and easily to tranfer a patient of any size so that he is scarcely aware of motion. The patient scheduled for surgery or extensive examination or treatment is placed on a special Tranpad mattress. The low-friction, airfoil top of the Trancar is then cranked effortlessly under the pad and returned, transferring both pad and patient laterally, on a horizontal level. Reversing the process, both pad and patient are placed on the surgical, x-ray or treatment table, or returned to the patient's bed. During the postoperative period, the Amsco Trancar may serve as a recovery bed and has Trendelen-



burg, Reverse Trendelenburg and I.V. facilities.

The Amsco locking devices adapt Trancar to 95 per cent of hospital beds and to virtually all operating, treatment and examining tables. There are practically no maintenance costs and no special training or skills are necessary for operation of the Trancar by personnel. The Trancar moves only the mattress pad on which the patient rests, thus the patient is not raised or lowered, due to the fingertip crank adjustment to bed or operating table height, and is not rolled or lifted. **American Sterilizer Co., Erie, Pa.**

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Available in six, ten or 14-bushel sizes, the new line of Rubbermaid plastic utility trucks has smooth surfaces, without corners or seams to trap dirt, and can be steam-cleaned. Easily mobile on four casters, the units may be used for meat and food handling as well as a linen center on wheels, and will not rust or dent. Trucks are available with hose or spigot for use in hospital laundries. **Rubbermaid Inc., Wooster, Ohio.**

For more details circle #6 on mailing card.

(Continued on page 192)

Optical Oscillograph Provides Direct Readout

The Model 658T Sanborn optical oscillographic recording system provides eight channels with direct readout and no chemical developing necessary. The system uses the versatile "350" series preamplifiers and provides the general advantages of optical recording with frequency range more than sufficient for blood pressures, EEG, ECG, oximetry, dye dilution studies, plethysmograms, temperatures and the like. The Sanborn 350-1700B Heart Sound Preamplifier provides pre-emphasis to extend the heart sound bandwidth and galvanometers with increased frequency range are available for other phenomena. The new system uses an eight-inch wide chart, has nine chart speeds, timing lines at 0.1 and 1.0 second intervals, and a beam interrupter for trace identification. **Sanborn Co., Medical Div., 175 Wyman St., Waltham 54, Mass.**

For more details circle #7 on mailing card.

G-E Cooking Center Features Microwave Units

Containing two complete and independently operated units, the General Electric Microwave Cooking Center reduces preparation time considerably. An accurate timer eliminates guesswork and a quality heat level is constantly maintained. Manufactured to close tolerances to lessen crevices which might accumulate unsanitary matter, the compact stainless steel unit is easily cleaned. **General Electric Co., Schenectady 5, N.Y.**

For more details circle #8 on mailing card.

Manually-Operated Bed Added to American Seating Line

The new Access-O-Manual bed, resembling in styling the Access-O-Matic introduced last year, is a manually-operated hospital bed with a high-low operation ranging from 19 to 27 inches, and knee and head adjustments as well as Trendelenburg and other treatment positions. The

83-inch long bed is designed for a standard 36 by 80-inch mattress, is 37 inches wide for easy clearance of a 38-inch doorway, and has inset telescoping legs and four-inch casters for quiet operation and easy mobility.

The bed is available as a basic unit with removable headboard and stationary footboard, finished in baked enamel for easy cleaning, and optional features include vinyl steel closure panels for sides and foot end, vinyl covered headboard, and a hinged footboard which permits extension of the bed to 86 inches in length. Corner bumpers, aluminum molding, safety rails, intravenous rod and fracture frame adapters are also available. **American Seating Co., Grand Rapids 2, Mich.**

For more details circle #9 on mailing card.

Dine-Line Serving Unit Reduces Labor and Food Costs

A buffet-type food service unit called the Dine-Line, designed to reduce labor and food costs, serves from both sides on a one-cost per meal basis, and contains

three units, one each for dishes, hot entree and cold foods. It is suitable for service in lunchrooms for employes, doctors, visitors and the like. **The Meal-on-Wheels Co., 5001 E. 59th St., Kansas City 30, Mo.**

For more details circle #10 on mailing card.

Two Rugged Linen Trucks Added to Jarvis & Jarvis Line

High strength, alloy alumium units, which combine rugged construction to

carry large linen loads, and light weight for easy mobility, are the newest addition to the Jarvis & Jarvis line of hospital linen trucks. Two models are available, a 14-compartment Model 2114 with linen capacity for 40 to 46 beds, and a smaller nine-compartment Model 2113, which accommodates linens for 32 to 36 beds. Mounted on double ball bearing rubber-tired wheels with swivel casters, the trucks can be pushed straight along corridors or sideways into linen closets. **Jarvis & Jarvis Div., United Service Equipment Co., Inc., Palmer Mass.**

For more details circle #11 on mailing card.

Antibiotic Sensitivity Test in Ready-to-Use Ankh Plate

The result of five years of research by Ankh Laboratories, the Ankh Plate is a ready-to-use antibiotic sensitivity test which provides a practical solution to the need for accurate tests in smaller hospitals lacking complete laboratory facilities and

in doctors' offices. Consisting of two parts, the Ankh Plate Top and Ankh Plate Bottom, the peg-plate method is conducted as follows: The sterile prepared agar media plate is inoculated with the specimen, the technician removes the peg plate containing the antibiotics from a foil pouch and places it on the agar plate, the two are fastened together with the tape provided and the test is placed in the Ankh Incubator where results can be ready in six to 18 hours incubation. Known quantities of antibiotics are placed on plastic pegs in the second plate and all material is instantly released upon contact with the agar surface, overcoming many problems previously encountered in agar diffusion testing of bacterial sensitivity. Results are easy to read, accurate and inexpensive. Each package contains material for six tests, and the Ankh Incubator for use with the system is available separately. **Intra Products, 4421 Salem Ave., Dayton 6, Ohio.**

For more details circle #12 on mailing card.

Ice-Cooled Croup Tent For Adults, Children

Providing variable humidity conditions and serving as an aerosol and oxygen therapy tent, the ice-cooled croup tent may be used for adults as well as infants and children. It is quickly set up and easily folded for storage. **National Cylinder Gas Div., 840 N. Michigan Ave., Chicago 11.**

For more details circle #13 on mailing card.

Chux Nursery Diapers Are Pre-sterilized, Disposable

Scientifically sterilized and disposable, the new Chux Nursery Diapers are designed for newborn infants under 10 pounds, to help reduce the chance of cross-infection. Featuring an inner facing of a new Sofnet fabric that extends over the edges of the pad to protect delicate skin and mucous membranes, the filler of the diaper has a special drainage pattern, and an embossed polyethylene backing serves as a moisture barrier and a firm anchor for pinning. Chux require no sterilization and remain sterile indefinitely when the package is not opened. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #14 on mailing card.

(Continued on page 194)

Ansercall Nurse-Patient System Is Transistorized and Complete

Instant patient-staff communication is provided with Ansercall, the new transistorized Edwards nurse call system. High speed connections without dialing or push buttons are effected, and priority can be given to intensive care patients through a selective answer system. Remote stations may be installed in utility rooms or at ends of corridors to permit answering without a return to the nursing station. As each call is answered, the system resets itself,

but a bedside reset and emergency audible signal call are available. By pressing a button, nurses can monitor patient rooms without leaving the desk, but an optional bedside privacy switch can be set when the patient is out of danger. Even with the privacy switch on, patients can initiate calls and hold two-way conversations with the nursing station.

The Ansercall master station is complete with hand set for privacy and a three-step volume control. Built-in speaker-microphones are available, and the amplifier is fully transistorized for maximum clarity and sensitivity. Ansercall is available in flush wall and desk mounting models as well as in compact desk-top units. Patient stations are offered in a variety of models, and rugged dome-type lamps and tamperproof cords are added features. **Edward Co., Inc., Dept. PR-H, Norwalk, Conn.**

For more details circle #15 on mailing card.

Personal Care Items in Handy Patient Kit

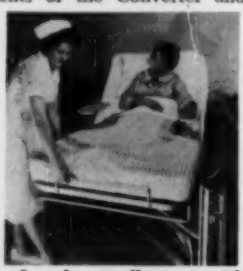
Ten personal care items for the patient's use during his hospital stay are included in the Kenwood Comfort Kit. The handy cardboard carrying case, personalized with the name and picture of the hospital, saves time and expense in issuing items and guards against cross infection. **Will Ross, Inc., 4285 N. Port Washington Rd., Milwaukee 12, Wis.**

For more details circle #16 on mailing card.

MacDonald Converter Makes Chair of Bed

Without touching the patient, the nurse can put him into sitting position with the MacDonald Converter, which can be attached to almost any make of hospital bed in ten minutes. It swings easily to either side of the bed and into a chair position from which the patient may be helped to stand on the floor when desired. A special foot rest adjusts to the height of the individual patient, provides resistance against forward slipping, prevents foot drop, and can be used as a foot tent when the patient is prone.

A specially designed Hospital Tension-Ease Airlon mattress by Englander is standard with the Converter. The mattress is constructed to follow the folding movements of the Converter and is pa-



tient-proof and non-allergenic. The Converter is adjustable to many different positions, including that with legs supported below horizontal as in a contour chair, and that of a straight chair when the patient is ready to sit straight up or to walk. The head section locks into six positions and the foot section into four. In addition, the Converter follows every movement of the Gatch spring for regular bed use. Removable arm rests give added comfort, convenience and security when the patient sits, and support for stepping off the bed. Strain is eliminated for nurse or attendant in moving even heavy patients with the Converter.

It is engineered of strong high carbon steel, mechanisms are engineered for

smooth mobility, and the built-in automatic locking devices are safety tested. **Bed Converter Corp., 24 California St., San Francisco 11, Calif.**

For more details circle #17 on mailing card.

Electronic Bedside Unit Centralizes Patient Controls

Originated by Mr. Boone Power, administrator of Baylor University Medical Center of Dallas, the Hill-Rom Executone Electronic Bedside Unit is a custom-designed, built-in patient station wardrobe combination with all patient service controls. The unit illustrated is installed at the new Kettering Hospital, Dayton, Ohio. A convenient nurse bar on the electronic control panel is pressed for patient-nurse communication, which includes illumination of the dome light, a chime and room number register at the nursing station. All lights are cancelled automat-

ically when the call is completed. Illuminated switches enable the patient to turn lights on or off, fingertip control of five television channels and radio are provided, and optional equipment includes a pillow speaker, telephone, utensil and luminous electric clock. Any or all of the units may be included in a custom design. **Hill-Rom Company, Inc., Batesville, Ind.**

For more details circle #18 on mailing card.

Operating Room Sweatband Is Cool and Comfortable

Disposable, featherweight and cool, the new Operating Room Sweatband of white gauze and cotton holds up to ten times its weight in moisture, and is light and comfortable to wear. **General Bandages, Inc., 8300 Lehigh Ave., Morton Grove, Ill.**

For more details circle #19 on mailing card.

Waterless Destroilet Destroys Human Waste Matter

A waterless, non-chemical toilet which transforms human waste matter into odorless, invisible, harmless water vapors and carbon dioxide is provided in the Destroilet. It operates on gas as fuel to burn off waste matter at extremely high temperature. The combustion process is com-

pletely controlled with dependable safety features, and installation also requires connection to a 110 volt AC electrical outlet and a flue for outlet of the waste vapor. Plumbing and septic tanks are not required, water savings are considerable and an exhaust fan draws off odors. **LaMere Industries, Walworth, Wis.**

For more details circle #20 on mailing card.

(Continued on page 196)

NOW
YOU
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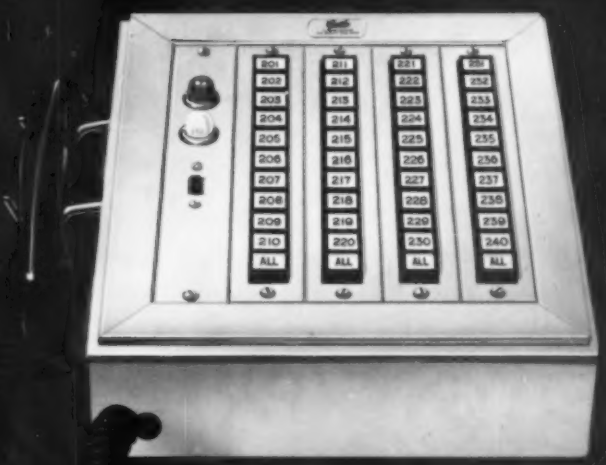
AFFORD...



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AUDIO-VISUAL TRANSISTORIZED *NURSES CALL SYSTEM*

Now *voice communication* is within your budget because Couch has simplified the wiring to save you major installation expense.

A twisted pair is all the additional wiring you need to convert a visual nurses call system to the new Couch audio-visual system. You save money by using existing wiring.

For new installations, this Couch system requires *less labor* and *fewer wires* than any other comparable system.

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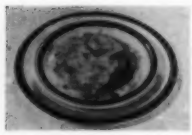
NURSES CALL SYSTEMS • STAFF IN AND OUT REGISTER SYSTEMS • STAFF VISUAL PAGING SYSTEMS
MODULAR FIRE ALARM SYSTEMS • PRIVATE TELEPHONE SYSTEMS

All-Purpose-Nebulizer for Oxygen-Humidity Control

Either cold or heated nebulization for a wide range of humidity to meet patient requirements, and to help solve problems of oxygen-humidity control and administration, is provided with the new All-Purpose Nebulizer introduced by Puritan. The design of the unit permits an interchange of accessories, including a choice of relief valves for catheter or mask systems. Either large or small bore tubing may be used, and in nursing care, a patented pushbutton orifice cleaner makes it possible to clean the orifice without interupting service. The Nebulizer can be autoclaved in its entirety as required. **Puritan Compressed Gas Corp., 13th & Oak St., Kansas City 6, Mo.**

For more details circle #21 on mailing card.



Tuna a la King Ready to Heat and Serve

Tuna a la King, pre-cooked and ready to heat and serve, has been added to the Sexton line of convenience foods for positive control and uniform quality. It reduces waste and cuts the expense of on-premise food preparation by skilled labor. **John Sexton & Co., P.O. Box J.S., Chicago 90.**

For more details circle #22 on mailing card.

Three Insti-Pack Soups in Campbell Institutional Line

A new line of Insti-Pack (short for institutional package) Soups, developed especially for the quantity food service field, is now offered by Campbell Soup. Different in appearance and taste from products currently available to the consumer, the three new soups are the first in what will be an expanded line. Included are a special formulation Vegetable Soup, Chicken Noodle Soup and Clam Chowder. The latter lends itself especially to variation by the addition of milk for New England style or of tomato

products for Manhattan-type. Insti-Pack soups are distinguished primarily by the cut of the meat, vegetables and other ingredients to make them look home-made, and retain the high Campbell quality. They are packed in 50-ounce cans. **Campbell Soup Co., Camden 1, N.J.**

For more details circle #23 on mailing card.

"Unit Spacefinder" System Provides Flexible Filing

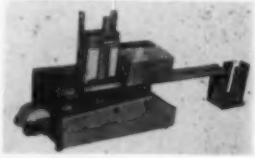
Flexibility, visibility and accessibility are features of the new "Unit Spacefinder" filing system which is composed of Unit Boxes and a sturdy, free-standing metal

frame. The boxes, constructed of rugged laminated fiberboard, are letter or legal size and can be easily carried, sliding freely back and forth on cross-rails in the frame, attached by their steel backs. Space is created by moving boxes laterally on rails. **Tab Products Co., 995 Market St., San Francisco 3, Calif.**

For more details circle #24 on mailing card.

"Nordamatic Addressor" Uses Typewritten Stencil

The compact, low-cost electric "Nordamatic Addressor" is capable of obtaining



more than 10,000 impressions from a typewritten stencil plate and is designed for high speed printing of 3,600 addresses per hour. **Nord Photocopy & Electronics Corp., 300 Denton Ave., New Hyde Park, N.Y.**

For more details circle #25 on mailing card.

(Continued on page 198)

Cartoon-Style Posters
Urge Patient Identification

Stressing the importance of positive patient identification with light, cartoon-style illustrations, a series of colorful posters is offered by Hollister to remind hospital personnel to check patient identity before administering treatment or medication. **Hollister Inc., 833 N. Orleans, Chicago 10.**

For more details circle #26 on mailing card.

Model 103 Photocopy Machine
Sells at Economical Price

Designed to sell at budget price, the new Model 103 Photocopy Machine will produce black on white permanent copies of anything drawn, printed, duplicated, typed or written. The low-silhouette machine will handle copy up to nine inches wide, of any length. **A. B. Dick Co., 5700 W. Touhy Ave., Chicago 48.**

For more details circle #29 on mailing card.

Shelleymatic Dispenser
Is Maintenance-Free, Efficient

The unique simple design of telescoping type elevators enables the Shelleymatic Model TCGS 2020 self-leveling cup and saucer dispenser to provide maintenance-free, efficient service for up to 12 dozen cups and saucers. The compact unit is available in portable and stationary models, heated or unheated. **Shelley Mfg. Co., 3800 N. W. 38th St., Miami, Fla.**

For more details circle #27 on mailing card.

Compact Utility Cart
Has Sound Deadened Shelves

The Compact, a low cost utility cart made of heavy gauge stainless steel, features six shelves which are sound deadened with underside padding. It is available in two models, 333 with shelf size 15¾ by 24 inches, and 344, 17¾ by 27 inches, both with a carrying capacity of 200 pounds. **Lakeside Mfg. Co., 1977 S. Allis St., Milwaukee 7, Wis.**

For more details circle #30 on mailing card.

AdjustoGrip Patient Gown
Fits All Sizes

Equipped with stainless steel Gripper snap fasteners arranged for adjustment to patients of practically any size, the new AdjustoGrip Patient Gown is made of extra-durable, super-soft percale cotton in a choice of colors. The Gripper fasteners are laundry proof to last the life of the garment, and the soft percale fabric is kind to the skin. **Fashion Seal Uniforms, 63 New York Ave., Huntington, N.Y.**

For more details circle #28 on mailing card.

Step-Out Style Scrub Dress
and No-Tie Operating Cap

The Angelica Step-Out style scrub dress has two gripper snaps at the neck and back opening to the waist so that it slips down to avoid the unpleasantness of over-the-head removal of a contaminated dress. It has attractive styling and is easily laundered. The new No-Tie Operating Cap has a hidden elastic band and fits all head sizes. **Angelica Uniform Co., 1429 Olive St., St. Louis 3, Mo.**

For more details circle #31 on mailing card.

Complete Intercom System Has Patient-Nurse Unit

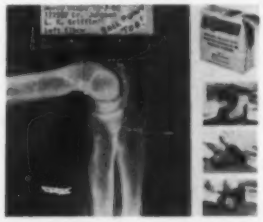
Two-way confidential conversation between nurse and patient is effected by a simple flick of a key with the Dictograph Nurses Station, part of a complete line of hospital communication equipment. When the patient presses a button at his side, a white light shows at his station and over his door, and a number signal light appears on the nurses Master Station. Unanswered calls remain registered, permitting the nurse to assign priority if two or more calls appear simultaneously. When a call is completed, the automatic release mechanism restores all keys and signal lamps associated with the call.

The Executive Station (upper photo) has a newly developed magic eye which indicates who is calling and automatically leaves a message if the administrator is away from his desk. It features hands-free operation, right-of-way priority and a conference circuit. The Master Station (lower photo) also has a magic eye indicator and can be used to initiate conferences with other staff members. The miniature transistorized Miracle Page message receiver is worn by doctors and hospital personnel for receiving individual messages. All units are part of the overall communication system and each can be installed separately as part of the hospital's present internal communications system. **Dictograph Products Inc., Danbury, Conn.**

For more details circle #32 on mailing card.

X-Rite Radio Opaque Labels Prevent X-Ray Misidentification

X-Rite Radio Opaque Tape is specially designed to reproduce copy directly on x-ray plates to prevent the possibility of misidentification of x-rays. Quickly prepared with typewriter, Address-O-Graph



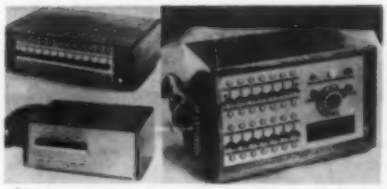
plates or ball point pen, the label is exposed with the object being x-rayed, and becomes a permanent part of the finished plate in a simple one-step operation. Full information can be included in minimum space and the adhesive backing eliminates sliding and misplacement of data. The self-adhering X-Rite Label is fixed to the cassette and exposed with the object. **X-Ray Identification Corp., 17110 Hartwell Ave., Detroit 35, Mich.**

For more details circle #33 on mailing card.

Protective Floor Seals for Heavy Traffic Areas

Terrazzo Floor Seal and Asphalt Tile Floor Seal are acrylic emulsion polymers which form tough films to seal and protect worn floors, or to prevent excess wear at heavy traffic points. The clear, colorless films have a high gloss and are grease and water resistant. **Banner Chemical Products Co., 9 Calumet St., Newark 5, N.J.**

For more details circle #34 on mailing card.



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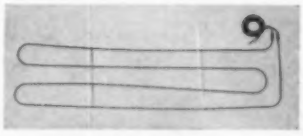


Snow-Bar Thawing Cable Frees Surfaces of Ice

Chromalox Thermwire Snow-Bar heating cable automatically keeps surfaces free of snow or ice build-up. Low in operating costs, the Snow Bar can be embedded in asphalt, macadam or concrete, or placed on present hard or gravel areas and covered with a layer or surfacing material. **Edwin L. Wiegand Co., 7500 Thomas Blvd., Pittsburgh 8, Pa.**

For more details circle #35 on mailing card.

Multi-Lead Thermometer Records at Nursing Station

A thermistor thermometer with several leads, permitting the reading of temperatures for several patients from a central source, is now in use in the Medical Physics Unit of the University of Edinburgh. Each lead is attached to a patient by placing the electrode in the axilla and fixing it with adhesive tape. Allowance is made for movement in bed, and for recording when the patient sits in an armchair beside the bed, by means of a rubber belt around the body. The thermometer itself is small enough to be deposited in the desk of the nursing station, where the nurse simply turns the central dial for patient selection in recording temperatures. Nursing time is thus saved, a continuing record can be made of a patient's temperature where indicated, and patients are not disturbed for the procedure. The product is not now available in the United States, according to our information.

For more details circle #36 on mailing card.

Dust Mop Treatment Eliminates Combustion

Life is the name of a new dust mop treatment developed to eliminate spontaneous combustion in dust mops, which also reduces the danger of infection from dustborne bacteria by attracting and holding dust particles in the mop. **National Chemsearch Corp., 2417 Commerce, Dallas 26, Tex.**

For more details circle #37 on mailing card.

(Continued on page 200)

Diet-Tray Cart Has Hot and Cold Compartments

Electrically pre-cooled and pre-heated, the Hospital Diet-Tray Cart has two interior fans which circulate hot and cold air in respective compartments for constant and continuous air recirculation. When the cart is unplugged, special self-rechargeable batteries continue fan operation within the compartments and correct holding temperatures are maintained until trays are assembled and served. The fully loaded cart moves easily on six ball bearing rubber wheels and non-rattle doors and a protective rubber bumper ensure quiet operation. **Southern Equipment Co., 4550 Gustine Ave., St. Louis 16, Mo.**

For more details circle #38 on mailing card.

Faster X-Ray Film for Shorter Exposures

Clearer images with shorter exposures are claimed for the new emulsion on the improved Kodak Royal Blue Medical X-Ray Film. Diagnostic procedures, particularly those where stopping involuntary body motion is important, are speeded and improved with the film, and exposure of the patient to x-rays is reduced. The high speed of the new emulsion is achieved with full manual film processing or by the Kodak medical X-Omat Processing System. The new film is available in sheets, rolls and Ready Packs, and combines high speed with low fog. **Eastman Kodak Co., Rochester 4, N. Y.**

For more details circle #39 on mailing card.

Spray-Buff Attachment Fits All Floor Machines

Simplified patching and restoring of floor finishes during routine buffing is effected with the new Spray-Buff attachment. It consists of a polished metal container which mounts on the handle of any make of floor machine, with a clear plastic hose leading to a spray nozzle. The container is equipped with a lever and discharge valve for spraying a wax-water or resinous-water solution on selected areas

which require special attention. **Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 16, Minn.**

For more details circle #40 on mailing card.

Institutional Shower Mat Has Non-Slip Pattern

Designed especially for institutional use, the new shower mat of soft, durable rubber has a non-slip pattern on the surface, knob back for aeration and 41 perforations for fast drainage. **American Mat Corp., 1719 Adams St., Toledo 2, Ohio.**

For more details circle #41 on mailing card.

Thermistor Thermometer in Two Basic Models

The Multi-Lead "Tape-On" model, designed for surface measurements, and the Esophageal Model in a one or two-lead design with the probe specifically designed

for esophageal or rectal application, are the two basic modifications of the new Electro-Medical Thermistor Thermometer. The "Lead-On" model shows instant reading of temperature at any one of four sites of application of a color-coded probe by turning the lead selector switch to the respective color-coded position on the switch dial. **Electro-Medical Engineering Co., Inc., 703 Main St., Burbank, Calif.**

For more details circle #42 on mailing card.

Mobile Model T-535 Caddy for Between Meal Nourishments

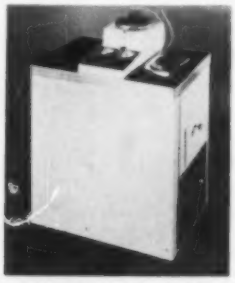
The Caddy Model T-535 is a self-contained mobile unit for complete between meal nourishment for patients. Included are a built-in refrigerator with ice cube trays and shelves for storage of milk, juices, butter and the like: beverage jugs for hot coffee or tea; a pop-up toaster; two paper cup dispensers, and ample storage for other food and supplies. A flat dispensing surface simplifies the work of the operator and record keeping is facilitated

as the unit can be loaded in the central kitchen. It is mounted on heavy duty casters, is encircled by a rubber bumper, and is constructed of all welded stainless steel with a white baked enamel refrigerator interior. **Caddy Corp. of America, Secaucus, N.J.**

For more details circle #43 on mailing card.

Gastric Hypothermia Machine for Gastrointestinal Bleeding

The Swenko Gastric Hypothermia Machine, developed and clinically tested at



the University of Minnesota, is now perfected for use in cases of upper gastrointestinal bleeding from a variety of causes. Combining a pump-refrigeration unit with a plastic catheter and a latex balloon to receive the cooling fluid, the machine is a completely closed system. **Swenko Mfg. Co., 2709 N. Washington Ave., Minneapolis 11, Minn.**

For more details circle #44 on mailing card.

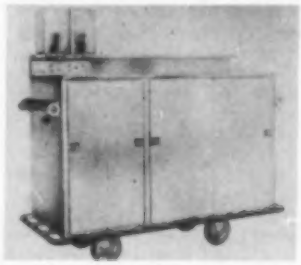
Improved X-Ray Fixative in Easy-Pour Plastic Jug

An improved formula which clears film faster and has greater capacity is offered in the new Phico-Fix fixative-hardener combination for use on film, x-ray film, movie film or paper. It is safe for use with automatic and semi-automatic machines and is formulated to be a highly stable, long lasting and even working fixing agent which imparts permanence to the image with maximum hardening of the emulsion. The new non-breakable plastic one-gallon container is easier to handle, store, and pour. **Philip Lochman & Co., 2405 Oakton, Evanston, Ill.**

For more details circle #45 on mailing card.

Food-ala-Cart Unit Has Full Length Top Shelf

A new model of the "Food-ala-Cart" hot and cold hospital food cart has several major improvements, including an added full length top shelf to permit sliding of beverage jugs to any location for dispensing, and end rails to prevent trays from being pushed off. The control panel has been moved from the end to the front for better visibility; the refrigerated section now has easy-to-clean radius corners; the deep freeze unit has been relocated for easier access, and the wheels have lifetime lubricated, double metal shielded ball bearings for easy mobility when loaded.



Nutting Truck and Caster Co., 1201 W. Division St., Faribault, Minn.

For more details circle #46 on mailing card.

(Continued on page 202)

For additional information, use postcard facing back cover.

Added Strength and Versatility in Redesigned Versarails

Redesigned with a new shape side rail for increased strength and versatility, the

new Lumex Versarails have the same safe "up" height but drop lower in the down position. They are designed to fit all makes and models of hospital beds and all styles and sizes of beds which may be used in nursing and geriatric care homes. **Lumex Inc., 1325 Newbridge Rd., Bellmore, N.Y.**

For more details circle #47 on mailing card.

Desk-Size Computer With Accounting Machine

An electronic data processing system with alphanumeric capability at reasonable price is offered by Burroughs. It integrates the Series E desk-size computer with a 10-total typewriter accounting machine which eliminates the need for additional units to write descriptive information on accounting forms. "Tri-plex input," which allows data to be fed into the system by adding two punched paper tape readers and a punched card unit, or three tape units, further extends the versatility of the computer. Programmer training requires only a few hours because of the simplified external pinboard command process. **Burroughs Corporation, Equipment & Systems Div., Detroit 32, Mich.**

For more details circle #48 on mailing card.

Kidde Kompact Extinguisher Features Fast Operation

The Kiddie Kompact, a two and one-half pound dry chemical fire extinguisher, featuring fast, self-evident operation and easy recharging, has a firm grip clamping band bracket which permits the extinguisher to be freed of the bracket with the pull of a finger for especially fast fire

protection. Both initial and replacement costs are low. **Walter Kidde & Co., Inc., 675 Main St., Belleville 9, N.J.**

For more details circle #49 on mailing card.

Explosion-Proof Receptacle for Operating Rooms

The explosion-proof Crouse-Hinds Type EHR receptacle used in combination with the Type EHP washable, watertight plug permits sanitation of the plug together with the extra protection of a grounded, keyed and flame-tight electrical receptacle. The EHP plug is especially keyed so that it is the only plug that will actuate the EHR receptacle, although the plug can also be used in standard Hubbellock receptacles. Three-wire construction provides the further safety of equipment

grounding. **Crouse-Hinds Co., Syracuse 1, N.Y.**

For more details circle #50 on mailing card.

Samco Glass and Bottle Crusher Is Portable, Compact, Safe

Portable and compact, the Samco Glass and Bottle Pulverizer reduces the storage space of defective bottles and other glassware, and pulverizes it to extremely minute particles. Safe and fast, it automatically deposits glass into a receptacle for disposal. **Syrall Mfg. Co., 511 N. State St., Syracuse, N.Y.**

For more details circle #51 on mailing card.

Swirlpool Hydrotherapy Unit Is Portable and Effective

Easily transported for use in bathtub or other basin as well as in special tank or tub, the Swirlpool hydrotherapy equipment affords both aerating and rapid swirling effects without requiring impellers or other moving parts in the tub with the patient. The completely portable Swirlpool motivating unit rests on the floor near the tub or vessel to be used, and draws water in from the tub through

a hose and forces it back into the tub through a second hose which has a special snorkle nozzle to create the aerated swirling flow of water. Force and direction of the water flow can be completely controlled by the nozzle. **E. F. Brewer Co., 13340 W. Carmen Ave., Butler, Wis.**

For more details circle #52 on mailing card.

Royal Scot Papers for Quality Photocopies

With the new contact speed Semi-Gloss paper introduced by Hunter, photographic prints of darkroom quality can be instantly reproduced from film negatives processed in Royal Scot copying machines. A companion S.W. Semi-Gloss projection speed photographic paper is also added to the line. With the papers, films can be exposed and processed in the same photocopy machine used for office paper work. **Hunter Photo Copyist, Inc., 568 Spencer St., Syracuse 4, N.Y.**

For more details circle #53 on mailing card.

Kant-Kink Tubes for Endotracheal Work

Kant-Kink Endotracheal Tubes are made with flat stainless steel wire embedded in a thin latex rubber wall. The wire extends from the patient's end to the special funnel end in one continuous spiral and will not kink, no matter how extreme the angle. A compression fit between the knurled lock nut on the connector and the funnel shaped machine end of the tube prevents accidentally pulling the tube off the connector. **Ohio Chemical & Surgical Equipment Co., 1400 E. Washington St., Madison 10, Wis.**

For more details circle #54 on mailing card.

Shenango American Chinaware Specially Designed for Hospitals

Designed for hospitals only, the new American Group of Shenango china ware is distributed by American Hospital Supply. The four handsome patterns brighten trays, and the china can be washed in boiling water and in automatic dishwash-

ers. Maximum body strength to keep breakage at an absolute minimum is achieved by the Micro-Mix method of pulverizing the mix that makes up the body of Shenango China, reducing air holes and fissures for a smoother, harder body. The Sta-Glaze finish is non-absorbent, giving a smooth, shining protection for stain resistance and easy cleaning. **American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill.**

For more details circle #53 on mailing card.

Pharmaceuticals

Cantilyn, Plain or With Neomycin

Cantilyn, a liquid containing Cantil, kaolin and pectin, for comprehensive symptomatic therapy in diarrheas, ulcerative colitis, diverticulitis and other spastic disorders of the lower GI tract, is also available with neomycin for diarrheas caused by neomycin-susceptible bacteria. It rapidly suppresses colonic motility and abdominal pain with minimal anticholinergic side effects. **Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 2, Wis.**

For more details circle #56 on mailing card.

Contac for Head Colds

Contac (short for continuous action) capsule is designed to provide all-day or all-night relief from running or stuffed-up nose, itching or weeping eyes, sneezing and other symptoms of the common cold or hay fever. It contains an antihistamine, a fast-acting decongestant and special drying agents, and is intended for administration once every 12 hours. Six hundred tiny "time pills" in each capsule disintegrate gradually and continually for maximum therapeutic effect. **Menley & James Laboratories, 1500 Spring Garden St., Philadelphia 1, Pa.**

For more details circle #57 on mailing card.

Quelidrine Syrup

Quelidrine Syrup is a fruit-flavored preparation for administration in all types of acute coughs without risk of addiction and undue sedation. It is designed to suppress the cough center, relieve allergic or inflammatory bronchospasm, control nasal congestion and help promote tracheobronchial secretion. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #58 on mailing card.

Torecan

A new phenothiazine compound possessing predominantly antiemetic properties, Torecan acts on both the chemoreceptor trigger zone and the true vomiting center to prevent or control nausea and vomiting in a wide variety of clinical conditions. **Sandoz Pharmaceuticals, Hanover, N.J.**

For more details circle #59 on mailing card.

White Laboratories, Inc., Kenilworth, N.J., announces the withdrawal from the market of Entoquel Syrup and Entoquel with Neomycin Syrup, antidiarrheals primarily for pediatric use, due to current divergence of medical opinion relating to the ability of infants and younger children to tolerate anticholinergics.

For more details circle #60 on mailing card.

Literature and Services

• **Hospital Sculptured Plaques** are the subject of a new six-page folder published by Meierjohan-Wengler, 1102 W. 9th St., Cincinnati 3, Ohio. Nearly 100 illustrations of Sculptured Plaques, Exterior Building Tablets, Add-A-Plate Tablets, Donor and Door Plates, Lighting Fixtures and Architectural Letters are shown in the folder, which presents new ideas in custom-fabricated M-W tablets and memorials in hand-finished bronze, aluminum and nickel silver.

For more details circle #61 on mailing card.

• The Toledo line of **Hi-Speed Choppers** is illustrated and described in **Form 3220**, a new four-page folder available from Toledo Scale Corp., Toledo 12, Ohio. Specifications on the bench and floor model choppers, ranging from ½ to 7½ h.p., are included.

For more details circle #62 on mailing card.

• The advantages and properties of **the original cotton cellular thermal blanket for hospitals** are described and illustrated in a colorful new leaflet released by Merryknit Sales Co., Old Greenwich, Conn. Subjects discussed include the economy, weightless warmth, resilience, freedom from linting, launderability and other features of Merryknit static-free and sterilizable blanket.

For more details circle #63 on mailing card.

• Prepared as a service to the health professions, the new **Nutrition Bulletin** published by Edward Dalton Co., Evansville 12, Ind., is presently released four times annually and reviews subjects of general interest in nutrition. In each issue a specific essential element in nutrition is reviewed, including such subjects as Electronic Cooking, Vitamin Deficiency, Nutrition in a Cold Climate, and others.

For more details circle #64 on mailing card.

(Continued on page 204)

• Done in story-telling form, the provocative motion picture, **"One Chance,"** released by the American Gas Assn., 420 Lexington Ave., New York 17, covers the important subject of sanitation in institutional kitchens. The 25-minute, 16mm sound, color film stresses proper dishwashing methods, plus checking and testing by health officials to determine whether the methods meet minimum sanitation requirements. Requests for Catalog No. 66/c will bring copies of the film, without charge, for showing to both management and personnel involved in volume feeding. Prints are also available through Economics Laboratory, Inc., 230 Park Ave., New York 17; Hobart Mfg. Co., Troy, Ohio; Ruud Mfg. Co., 2nd National Bank Bldg., Connellsville, Pa.; A. O. Smith Corp., Permaglas Div., P.O. Box 28, Kankakee, Ill., or your local gas company.

For more details circle #65 on mailing card.

• Electric-powered Trucksters, from one-passenger to five-passenger with luggage capacity, are described and illustrated in a new eight-page catalog entitled **"Twice the Power for Cushman Trucksters."** Available from Cushman Motors, 900 N. 21st St., Lincoln 1, Neb., the booklet discusses the many uses of both gasoline and electric-powered Trucksters in carrying personnel, supplies and equipment within and between institutional buildings. Twelve typical applications of these versatile units are pictured and many more are described.

For more details circle #66 on mailing card.

• Full details and illustrations of the new **Green Label all-purpose Porta-Dolly,** designed to transport mop buckets, liquid container drums, and refuse cans, is presented in a catalog sheet available from Market Forge Co., Everett 49, Mass.

For more details circle #67 on mailing card.

• Toro Mfg. Co., 3042 Snelling Ave., Minneapolis 6, Minn., announces a free **Toro Planning Service.** Toro distributors will analyze grass-cutting problems and needs, the condition and value of present mowing equipment, maintenance and manpower costs, and present a written proposal on how to do the job fast and economically. The service is designed to assure the best possible equipment for the individual problem.

For more details circle #68 on mailing card.

• Entitled **"How To Get The Most Out of Steam Cleaning With Oakite Specialized Detergents,"** a four-page illustrated booklet released by Oakite Products, Inc., 118A Rector St., New York 6, offers a concise compilation of the most modern methods and materials currently used in steam-detergent cleaning.

For more details circle #69 on mailing card.

Suppliers' News

All assets of **Aatell & Jones, Inc., Philadelphia, Pa.,** manufacturer of paper products for food service, have been taken over by **Sorg Products Co., Middletown, Ohio,** a subsidiary of **The Sorg Paper Co.** The company will continue operations as the **Aatell & Jones Division of the Sorg Products Co.**

Bloomfield Industries, Inc., 4546 W. 47th St., Chicago 32, manufacturer of food service equipment, announces acquisition of the **Silex Restaurant Equipment Division of Proctor-Silex Corp.**

Geerpres Wringer, Inc., P.O. Box 658, Muskegon, Mich., manufacturer of floor mopping equipment, announces its fourth major plant expansion, doubling its manufacturing facilities and including enlarged and improved shipping space and handling.

The Hard Mfg. Co., Box 427, Buffalo 5, N.Y., manufacturer of hospital furniture and equipment, announces a **ten-year warranty** on the **All-Ektrik automatic electric bed** recently introduced.

Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 2, Wis., manufacturer of pharmaceutical products, announces the opening of a new **Research Center** housing laboratories and offices for basic and applied research.

Royal Metal Mfg. Co., One Park Ave., New York 16, manufacturer of institutional furniture, announces formal opening of its new plant in **Michigan City, Ind.,** to house factory and office and provide additional manufacturing facilities to meet the growing needs for its products.

Rubbermaid Incorporated, Wooster, Ohio, manufacturer of rubber and plastic products, announces the acquisition of a new subsidiary, **Fusion, Incorporated, Statesville, N.C.,** for the manufacture of the new line of fusion molded products.

INDEX TO ADVERTISEMENTS

USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

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USE THIS CARD — (We pay the postage)

I am interested in the items circled— **December, 1961**

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☐ **Enter my One Year Subscription To Modern Hospital ($5), Foreign ($7)**

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(continued from preceding page)

(HPF) after company name indicates that further descriptive data are filed in catalog space in Hospital Purchasing File 1961 Edition.

NEW topical corticosteroid provides superior anti-inflammatory and antipruritic activity

CORDRAN™

(flurandrenolone, Lilly) (6α-fluoro-16α-hydroxyhydrocortisone 16,17-acetonide)

. . . and to combat infection

CORDRAN™-N

(flurandrenolone with neomycin sulfate, Lilly)

To provide greater flexibility in usage, Cordran and Cordran-N are available in both a cosmetically acceptable vanishing cream and a hydrophilic ointment base.

Description: Cordran cream and ointment are new corticosteroid preparations for topical use. Each Gm. contains 0.5 mg. Cordran.

Cordran-N cream and ointment combine Cordran and a safe, effective wide-spectrum antibiotic, neomycin. Each Gm. contains 0.5 mg. Cordran and 5 mg. neomycin sulfate (equivalent to 3.5 mg. base).

The cream base is composed of stearic acid, cetyl alcohol, liquid petrolatum, polyoxyl 40 stearate, ethyl parahydroxybenzoate, glycerin, and purified water. The ointment base is composed of white beeswax, cetyl alcohol, sorbitan sesquioleate, and white petrolatum.

Side-Effects: No side-effects have been reported to date from the use of either the cream or ointment forms of Cordran and Cordran-N.

Contraindications and Precautions: Cordran and Cordran-N should not be used in the presence of tuberculosis of the skin, nor should they be used in the eyes.

If secondary bacterial infections of the skin are present prior to the use of Cordran, they should be treated also with appropriate anti-infective measures. If the infection present before the application of Cordran or Cordran-N, or developing during its use, does not respond promptly, discontinue the preparation until the infection has been adequately controlled.

Patients with superficial fungus or yeast infections should be treated with additional appropriate methods and must be under constant medical observation.

Although sensitivity has not been reported, a few individuals may be sensitive to these preparations. If any reaction indicating sensitivity is observed, discontinue the use of the product. If a patient has a proved idiosyncrasy to neomycin, another antibiotic may be used along with Cordran.

Since use of antibiotic agents may cause overgrowth of nonsusceptible organisms, constant observation of the patient is essential.

Administration and Dosage: Cream—For moist, weeping lesions. Rub a small quantity of cream gently into the affected areas two or three times daily. Vigorous application is not necessary and may damage the skin.

Ointment—For dry, scaly lesions. Apply a small quantity of ointment as a thin film to the affected areas two or three times daily.

How Supplied: All product forms are supplied in 7.5 and 15-Gm. tubes.

Lilly

1402-41

CERAMAFLEX®... *newest development of Romany•Spartan research. Sixty-four ceramic mosaic tiles securely bonded in a resilient rubber grid, pre-grouted and laid quickly and inexpensively in 9" squares. Quiet and comfortable underfoot. Choose from 12 attractive Buckshot® patterns for installation over any sound sub-floor above, on or below grade.*

Plate No. 2004

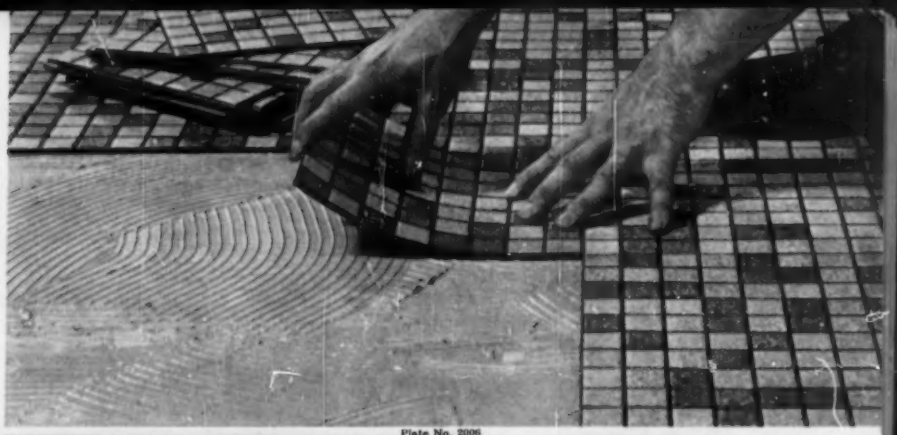

Plate No. 2006

Romany • Spartan provides extra cleanliness wherever food is prepared or served.

Plate No. 2007

Washroom walls and floors of Romany• Spartan stay fresh and clean with little care.

eye-appealing...
enduring...
easily maintained...

Plate No. 2008

Ceramaflex is ideal in lobby and corridors— attractive, quiet and comfortable underfoot.

Plate No. 2008

Operating room floors of Romany•Spartan conductive tile add an extra margin of safety.

...floors and walls of Romany•Spartan

The use of ceramic tile throughout the hospital offers many well known advantages, but when you choose Romany•Spartan you get even more. There's Level-Set® glazed wall tile in a complete range of beautiful colors. Level-Set is edge-ground, the world's *only* precisely sized 4¼" wall tile. This means extra setting speed, and because of its thin, straight joints—the most attractive installation you've ever seen.

Then there's Ceramaflex®, the world's *only* resilient ceramic floor covering. Ceramaflex gives you all the advantages of ceramic floor tile, yet it's soft and quiet underfoot. There are glazed and unglazed ceramic mosaics, too, in a myriad of patterns and designs, back-mounted for faster installation. Consult your architect. He can show you samples and provide more information. United States Ceramic Tile Company, Dept. MH-24, Canton 2, Ohio.

ROMANY
SPARTAN®
CERAMIC TILE

MEMBER

UNITED STATES CERAMIC TILE COMPANY

Ceramaflex® is the exclusive product of United States Ceramic Tile Company